NATIONAL HEALTH INSURANCE PROPOSALS

Provisions of Bills
Introduced in the
94th Congress
as of
February 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
OFFICE OF RESEARCH AND STATISTICS

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Compiled by
SAUL WALDMAN

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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FOREWORD

The need for a national health insurance program to help finance the cost of medical care has been a subject of continuing discussion and debate. Health care costs are currently financed by both private and public efforts with most private financing being various employment-related and individual insurance plans, as well as out-of-pocket payments by the patient. In the public sector, a diversity of Federal, State, and local insurance and assistance and service programs finance certain health costs for designated population groups.

Proposals for national health insurance represent, in part, an effort to make available to the entire population a specified level of health care protection. Some proponents of national health plans, concerned with increasing health costs, emphasize the potential of a national program to apply cost control mechanisms. Others view a national health plan primarily as a device for bringing about a reorganized delivery of health services.

Opinions vary widely on the most desirable approach. The programs proposed would be implemented either through a single plan or through a combination of plans, with various existing health programs eliminated, absorbed, or continued. Alternative sources of financing a program include private insurance premiums, Federal earmarked taxes or general revenues, State funds, and mixtures of these sources. Among the options offered for administration are use of insurance carriers and other private organizations, Federal and State governmental agencies, and various combinations of the private and public sections. Some proposals permit voluntary participation in various aspects of the plan while others are based on a mandatory approach.

This report, designed as an aid to analysis of the various proposals, offers detailed information on the provisions of all national health insurance bills introduced in the 94th Congress as of February 1976. It is an updating of similar reports released in prior years by ORS and now out of print. The report offers a convenient summation for responding to continuing requests for information from the Department, the Congress, and the health care research community. The common analytical framework employed by the author, Saul Waldman of the Division of Health Insurance Studies, has proven useful for many research purposes. William J. Sobaski, also of the DHIS staff, made significant contributions in the review of the study. Alberta Thompson of the Publications Staff provided editorial assistance.

John J. Carroll
Assistant Commissioner for Research and Statistics.

March 1976.

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INTRODUCTION

This report includes the 18 national health insurance bills introduced in the 94th Congress as of February 1976. For this report, a national health insurance program is defined as one which would at least (1) establish a plan by law or provide substantial incentives for its voluntary establishment, (2) use some type of insurance or tax mechanism, and (3) potentially affect all or most of the population.

To aid in comparison, the plans have been grouped according to their general approach as follows:

(1) Mixed public and private

(2) Mainly public

(3) Tax credit

(4) Catastrophic protection

Classifying the proposals into these groups necessarily involves a degree of arbitrariness. Plans which fall into the tax credit and catastrophic protection categories are classified as such and all other plans are divided between the mixed public and private and the mainly public groups, based on consideration of the degree of government involvement in the plans. It might be noted that while the two catastrophic plans both limit their benefits for the general population to persons with unusually high health expenses, they both also provide basic health benefits for the low-income population. Also, the Fulton bill which is included in the tax credit group incorporates both a tax credit mechanism and a mandated employer plan.

Table A lists the bills by name, bill number, first sponsor in the House and Senate, and indicates any announced support by major national organizations. A comparison is also made of these bills with those introduced in the 93rd Congress indicating that most of them are identical to or are modifications of bills introduced in the last session. Of the bills supported by major national organizations, five have been reintroduced, all of them in modified form. A bill similar to the Administration bill in the 93rd Congress has been reintroduced by Representative Carter (H.R. 4747). This bill was not introduced on behalf of the Administration which has not proposed any national health insurance bill in this session.

To facilitate analysis and comparison, the provisions of all the bills have been presented in a manner which provides information on the following subjects:

(1) General concept and approach

(2) Coverage of the population

(3) Benefit structure

(4) Administration

(5) Relationship to other government programs

(6) Financing

(7) Standards for providers of service

(8) Reimbursement of providers of service

(9) Delivery and resources

Many of the bills include provisions specifically designed to effect changes in the methods of delivery of health care services or to increase the supply of health resources. These provisions are included in the category of delivery and resources. Of course various other provisions of the bills, especially those concerning standards for providers and methods of reimbursement, could often have significant effects on health delivery and resources.

Many of the plans have established the standards for providers of service to participate in the program by reference to the standards used in the Medicare law. A description of these Medicare standards is shown in the Appendix.

Summary charts describing the major features of the proposals follow. The chart for H.R. 3674 introduced by Representative Matsunaga has been omitted because it would be identical to the chart prepared for the Corman-Kennedy bill (H.R. 21 and S. 3). The differences between these two bills are explained in the text.

TABLE A.--LISTING OF NATIONAL HEALTH INSURANCE BILLS INTROOUCEO IN THE 94th CONGRESS, BY TYPE OF PROPOSAL, FEBRUARY 1976

Type and name of bill	First sponsor		Bill number		Supported by national organization	Comparison with bills introduced in the 93rd Congress
	House	Senate	House	Senate		
Mixed public and private						
The National Health Care Services Reorganization and Financing Act	Ullman		H.R. 1		American Hospital Association.	Modified.
The National Health Care Act of 1975	Burleson	McIntyre	H.R. 5990	S. 1438	Health Insurance Association of America.	Modified.
The National Health Standards Act		Fannin		S. 2644	U.S. Chamber of Commerce.	Modified.
The Comprehensive Health Insurance Act of 1974	Carter		H.R. 4747			Similar to Administration-supported bill.1/
National Comprehensive Health Benefits Act of 1975	Staggers		H.R. 2049			Identical.
National Family Health Protection Act	Lujan		H.R. 3672			Identical.
Mainly public						
The Health Security Act	Corman	Kennedy	H.R. 21	S. 3	AFL-CIO, Committee for National Health Insurance.	Modified.
The Health Security Act	Matsunaga		H.R. 3674			New.2/
National Health Insurance Act	Oingell		H.R. 94			Identical.
Comprehensive National Health Care Act of 1975	Young		H.R. 10888			New.
National Voluntary Medical and Hospital Services Insurance Act of 1975	Ketchum-Lagomarsino		H.R. 3252			Modified.
Tax credits						
Comprehensive Health Care Insurance Act of 1975	Fulton		H.R. 6222		American Medical Association.	Modified.
Health Care Insurance Act of 1973	Downing		H.R. 363			Identical to Fulton-Broyhill bill in 93rd Congress.
Health Care Insurance Act of 1975	Bennett		H.R. 93			Identical to Fulton-Broyhill bill in 92nd Congress.
Medical Expense Tax Credit Act		Brock		S. 600		Modified.
Basic Health Insurance Tax Credit and Medical Assistance Act	Clawson		H.R. 10562			New.
Catastrophic protection						
Catastrophic Health Insurance and Medical Assistance Reform Act	Waggonner	Long-Ribicoff	H.R. 10028	S. 2470		Modified.
National Catastrophic Illness Protection Act of 1975	Roe		H.R. 1373			Identical.

1/ The Administration has not introduced a national health insurance bill in the 94th Congress.
2/ Similar to Corman-Kennedy bill.

Mixed public and private--ULLMAN BILL

Subject	Provisions	
General concept and approach	A 3-part program including: (1) a plan requiring employers to provide private coverage for employees, (2) a plan for individuals, and (3) federally contracted coverage for the poor and aged. State establishes a health care plan, supervises carriers and insurers, and promotes a system of health care corporations (HCC). Supported by American Hospital Association.	
Coverage of the population	Private plans	Plan for low income and aged
	Employees of employers under social security and of State and local governments. Also, individuals who elect coverage.	Low-income and medically indigent families, and aged persons.
Benefit structure	Benefits phased in over 5-year period. Final benefits: Institutional services: Hospital: 90 days, $5 copayment per day. Skilled nursing facility: 30 days, $2.50 copayment per day. Nursing home: 90 days, $2.50 copayment per day. Personal services: Physicians: 10 visits per year, $2 copayment per visit. Laboratory and X-ray: 20 percent coinsurance. Home health services: 200 visits per year, $2 copayment per visit. Dental services: Children age 7-12: 1 exam per year, other services, 20 percent coinsurance. Other services and supplies: Prescription drugs: Limited to specified conditions, $1 per prescription. Medical equipment and appliances and ambulance service: 20 percent coinsurance. Eyeglasses: Children to age 12, 1 set per year, 20 percent coinsurance. Catastrophic coverage: Payable when certain noncovered expenses reach a specified limit, which varies by family income and age; would remove the cost sharing on all benefits and the limitation on number of hospital days and physicians' visits.	
Administration	Administered by private insurance carriers under State supervision, according to Federal guidelines.	Federal Government would contract with private insurance carriers who issue policies to eligible persons.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Mostly not affected.	
Financing	Employee-employer premium payments, with employer paying at least 75 percent. Federal subsidy of premium for low-income workers and certain small employers, and 10 percent subsidy for HCC enrollees. Individuals pay own premium.	Financed in part by premium payments by medically indigent, but with no premium for lowest income group. Balance of cost financed by Federal general revenues and the payroll taxes of the present Medicare program.
Standards for providers of services	All institutions and HCC's must meet Medicare standards. Skilled nursing facilities must be under supervision of a hospital medical staff or have its own organized staff. Use of paramedical personnel must meet Federal standards. All providers and HCC's must establish systems of peer review, medical audit and other procedures to meet Federal-State requirements on quality and utilization of services.	
Reimbursement of providers of services	Institutions and HCC's: State commission would establish prospective payment methods and review proposed charges. Physicians and other professionals: Reasonable fee, salaries, or other compensation, as approved by State commission.	
Delivery and resources	State health commission: Establishes a State health plan, including provisions for regulation of providers and insurance carriers. Takes responsibility for health planning and must approve, in advance, proposed capital expenditures of providers. Health care corporations: State commissions would incorporate system of HCC's, approved to operate in designated geographical areas. HCC must furnish all covered services through its own facilities or affiliated providers (and permit all qualified practitioners to furnish services for it). Would be required to hold open enrollment for public and eventually offer services on a capitation basis. Federal grants provided for HCC's for planning, development, outpatient centers, medical and data equipment, and to cover initial operating deficits.	

Mixed public and private--BURLESON-McINTYRE BILL

Subject	Provisions	
General concept and approach	A 3-part plan including a voluntary employee-employer plan and a plan for individuals, under which contributors would receive tax advantages, and a State plan for the poor. All plans administered through private insurance carriers and provide same benefits. Supported by the Health Insurance Association of America.	
	Private plans	State plan
Coverage of the population	Employee-employer plan includes employees (and their families) of employers who voluntarily elect a qualified plan. Individual plan includes persons who voluntarily elect.	Low-income families.
Benefit structure	Benefits phased-in over a 8-year period, final benefits as follows: Deductible of $100 per person and 20% coinsurance, except where noted. Institutional services: Hospital. Skilled nursing facility: 180 days. Personal services: Physicians. Dentists. Home health services: 270 days. Laboratory and X-ray: No cost sharing. Health exams and family planning. Well-child care with no cost sharing. Other services and supplies: Medical appliances. Eyeglasses. Prescription drugs.	
	Annual limit for all cost sharing of $1,000 per family.	Reduced cost sharing and family maximum, according to family income.
Administration	Insurance administered by private carriers under State supervision. Treasury Department determines tax status of plan.	Insurance administered by private carriers under agreement with the State. Regulations for program established by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under programs. Other programs: Most not affected.	
Financing	For employee-employer plan, premium paid by employers and employees, as arranged between them, but contributions of low-income workers limited according to their wage level. For individual plan, policyholder pays entire premium. Employees and individuals who itemize deductions can take entire premium as deduction on income tax return.1/ Employers can take their entire premium as normal business deduction as under present law (but contributions to nonqualified plans would not be deductible).	No premium required for lowest income group; for others, premium paid by enrollees, varying according to family income. Federal and State governments pay balance of costs from their general revenues, with Federal share 70 to 90 percent, depending on State per capita income.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Prospectively approved rates for various categories of institutions. Hospitals prepare budgets and schedule of charges which are reviewed by a State commission which approves or disapproves charges, subject to DHEW review of rate levels. Physicians and dentists: Reasonable charges, based on customary and prevailing rates.	
Delivery and resources	Health planning: Planning agency approval required for capital expenditures to be recognized for reimbursement. Health maintenance organizations: Must be made available as an option to persons enrolled in State plan. Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers. Health manpower: Increases loans and grants for students, with special provisions for shortage areas.	

1/ Under present law, deduction of premium is limited to one-half the premium cost up to a maximum of $150.

Mixed public and private--FANNIN BILL

Subject	Provisions	
General concept and approach----------	A 2-part program including (1) a plan requiring employers to offer health insurance coverage to their employees and (2) a State plan for low-income families. Supported by U.S. Chamber of Commerce.	
	Employer-employee plan	Low-income plan
Coverage of the population----------	Full-time employees, including employees of Federal, State, and local governments.	Low-income families.
Benefit structure----------	No limit on amount of benefits, except where indicated: Institutional services: Hospital. Skilled nursing facility: By regulation. Personal services: Physicians. Laboratory and X-ray. Other services and supplies: Prescription drugs. Medical supplies and appliances.	
	Deductible of $100 per person and 25 percent coinsurance, but total limit to $2,600 annually per family. Actuarially equivalent benefits may be substituted for specified ones.	10-percent coinsurance, but limited to 5 percent of annual family income.
Administration----------	Private health insurance carriers (or self-insured arrangements) supervised by the States, under Federal regulations.	Administered by States through private carriers.
Relationship to other Government programs--	Medicare: Continues. Medicaid: Abolished. Other programs: Most not affected.	
Financing----------	Employee-employer premium payments, with employer required to pay at least 50 percent of cost. Special pools for small employers and self-employed.	Premium payments from enrollees according to family income, with none for lowest income group. Balance of cost from Federal general revenues.
Standards for providers of services--------	Same as under Medicare.	
Reimbursement of providers of services-----	Institutions: Prospective budgets with uniform payment rates per specified period of time (e.g. per day) for all patients. Physicians: Usual and customary charges.	
Delivery and resources----------	Health maintenance organizations: Under both plans, option available to enroll in approved HMO's. Professional Standards Review Organization (PSRO): Would apply to all services under program. Regulation of providers: Proposed and existing capital facilities and services must be approved by local planning agency.	

Mixed public and private--CARTER BILL

Subject	Provisions		
General concept and approach----	A 3-part program including: (1) a plan requiring employers to provide private health insurance for employees, (2) an assisted plan for the low-income and high medical-risk populations, and (3) an improved Federal Medicare program for the aged. The States would supervise providers of health service and insurance carriers, under Federal guidelines. Supported by the Administration in the 93rd Congress.		
	Employee plan	Assisted plan	Plan for aged
Coverage of the population------	Full-time employees, including employees of State and local governments.	Low-income families, employed or nonemployed. Also, families and employment groups who are high medical risks.	Aged persons insured under social security.
Benefit structure----------	No limits on amount of benefits listed below, except where indicated: Institutional services: Hospital inpatient and outpatient. Skilled nursing facility: 100 days per year. Personal services: Physicians. Dentists: For children under age 13. Laboratory and X-ray. Home health services: 100 visits per year. Family planning, maternity care, and health examinations; by regulation. Other services and supplies: Prescription drugs. Medical supplies and appliances. Eyeglasses and hearing aids (and eye and ear exams): For children under age 13.		
	Deductible of $150 per person and 25 percent coinsurance, but total cost sharing limited to $1,500 annually per family ($1,050 for individuals).	Maximum cost sharing provisions are same as employee plan, but reduced according to individual or family income.	Deductible of $100 per person and 20 percent coinsurance, but total cost sharing limited to $750 per person annually. Reduced cost sharing according to individual income for low-income aged.
Administration----------	Insurance through private carriers (or self-insured arrangements) supervised by States, under Federal regulations.	Administered by States, using private carriers to administer benefits, under Federal regulations.	Administered by Federal Government in way similar to present Medicare program.
Relationship to other Government programs----------	Medicare: Program continues as the Federal plan for the aged. Medicaid: No Federal matching funds for covered benefits (or for premiums or cost sharing) under new program, but continues for specified noncovered services (such as intermediate-care facilities).		
Financing----------	Employer-employee premium payments, with employer paying 75 percent of premiums (65% for first 3 years). Temporary Federal subsidies for employers with usually high increases in payroll costs. Special provisions to assure coverage for small employers.	Premium payments from enrollees according to family income (none for lowest income groups). Balance of costs from Federal and State general revenues, with State share varied according to State per capita income.	Continuation of present Medicare payroll taxes and premium payments by aged (but no premiums for low-income aged). Federal and State general revenues used to finance reduced cost sharing and premiums for low-income aged.
Standards for providers of services----------	Similar to Medicare, with additional standards for participation of physicians' extenders.		
Reimbursement of providers of services----------	Reimbursement rates established by States, according to Federal procedures and criteria. Providers of service who elect as "full participating" would be paid the State-established rates, including the cost sharing, as full payment of their charges. Providers who elect as "associate participating" could charge more than the State rate for employee plan patients, but must collect the extra charges and cost sharing from the patients. However, all hospitals and SNF's must be full participating providers.		
Delivery and resources----------	Prepaid practice plans: Under all plans, option available to enroll in approved prepaid group or individual practice plans (which meet special standards). Regulation of insurance carriers: By State, including approval of premium rates, enforcement of disclosure requirements, annual CPA audit, and protection against insolvency of carriers. Regulation of providers: By State, including standards for participation in program, approval of proposed capital expenditures, and enforcement of disclosure requirements. Professional Standard Review Organization (PSRO): Applies to all services under program.		

Mixed public and private--STAGGERS BILL

Subject	Provisions	
General concept and approach	A 3-part program: (1) a plan requiring employers to provide private coverage for employees, (2) a plan for individuals, and (3) federally contracted plan for the poor and aged. State establishes a health care plan, supervises carriers and insurers, and promotes a system of health maintenance organizations (HMO's).	
	Private plans	Plan for low income and aged
Coverage of the population	Employees and their families of employers subject to the social security tax. Also, other persons who elect coverage.	Low-income and medically indigent families, and aged persons.
Benefit structure	Benefits phased in over 6-year period. Final benefits: Institutional services: Hospital: 60 days, $5 copayment per day. Skilled nursing facility: 30 days, $2.50 copayment per day. Nursing home: 60 days, $2.50 copayment per day. Personal services: Physicians: 50 visits per year, $3 copayment per visit. Laboratory and X-ray: 20 percent coinsurance. Home health services: 100 visits per year, $2 copayment per visit. Dental services: Children age 7-12: 1 exam per year; other services, 20 percent coinsurance. Other services and supplies: Prescription drugs: Limited to specified conditions, $1 per prescription. Medical equipment and appliances and ambulance service: 20 percent coinsurance. Eyeglasses: Children to age 15, 1 set per year, 20 percent coinsurance. Catastrophic coverage: Payable when certain noncovered expenses reach a specified limit, which varies by family income and age; would remove the cost sharing on all benefits and the limitation on number of hospital days and physicians' visits.	
Administration	Administered by private insurance carriers under State supervision, according to Federal guidelines.	Federal Government would contract with private insurance carriers who issue policies to eligible persons.
Relationship to other Government programs	Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.	
Financing	Employee-employer premium payments, with employer paying at least 75 percent. Federal subsidy of premium for low-income workers and certain small employers; and 10 percent subsidy for HMO enrollees. Individuals pay own premium.	Financed in part by premium payments by medically indigent, but with no premium for lowest income group. Balance of cost financed by Federal general revenues.
Standards for providers of services	All institutions and HMO's must meet Medicare standards. Use of paramedical personnel must meet Federal standards. All providers must meet Federal-State quality and disclosure requirements.	
Reimbursement of providers of services	Institutions and HMO's: State commission would prospectively approve charges based on review of budget and schedule of proposed charges. Physicians and other professionals: Reasonable fee, salaries, or other compensation, as approved by State commission.	
Delivery and resources	State health commission: Establishes a State health plan, including provisions for regulation of providers and insurance carriers. Takes responsibility for health planning and must approve, in advance, proposed capital expenditures of providers. HMO's: State commissions would regulate a system of approved HMO's. HMO must furnish all covered services through its own facilities or other providers (including arrangements with medical groups or individual practice associations). Would be required to hold open enrollment for public and must eventually offer services on a capitation basis. Federal grants provided for planning, development, outpatient centers, and initial operating expenses.	

Mixed public and private--LUJAN BILL

Subject	Provisions
General concept and approach----------	A plan under which the Federal Government would issue certificates to families to purchase private health insurance.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	No limits on amount of benefits and no cost sharing, except where indicated: Institutional services: Hospital: Extended care facility: } No cost sharing for 120 days; afterward, 20 percent to 50 percent of cost. Personal services: Physicians: $50 deductible, maximum of $5 per visit. Laboratory and X-ray. Home health services. Other services and supplies: Medical equipment and supplies. Maternity care: $100 deductible.
Administration----------	Families would apply for a health protection certificate on their Federal income tax return. The certificate would be accepted by carriers as full premium payment for a qualified health insurance policy.
Relationship to other Government programs--	Medicare: Abolished. Medicaid: Abolished. Other government programs: Not affected.
Financing----------	Financed by a 5-percent surcharge on Federal personal income taxes. Federal Government would redeem certificates from carriers for their actuarial value.
Standards for providers of services--------	Same as under Medicare.
Reimbursement of providers of services-----	Institutions: Same as Medicare.
Delivery and resources----------	No provisions.

Mainly public--CORMAN-KENNEDY BILL

Subject	Provisions
General concept and approach	A program administered by Federal Government and financed by special taxes on earned and unearned income and by Federal general revenues. Supported by Committee for National Health Insurance and AFL-CIO.
Coverage of the population	All U.S. residents.
Benefit structure	Benefits with no limitations, except as noted. No cost sharing by patient. Institutional services: Hospital. Skilled nursing facility: 120 days. Personal services: Physicians. Dentists: For children under age 15; scheduled extension to age 25; eventually to entire population. Home health services. Other health professionals. Laboratory and X-ray. Other services and supplies: Medical appliances and ambulance services. Eyeglasses and hearing aids. Prescription drugs needed for chronic illness and other specified diseases.
Administration	Federal Government: Special board in DHEW, with regional and local offices to operate program.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.
Financing	Special taxes: On payroll (1.0% for employees and 2.5% for employers), self-employment income (2.5%) and unearned income (2.5%). Income subject to tax: Amount equal to 150% of earning base under social security (i.e., $22,950 in 1976). Employment subject to tax: Workers under social security and Federal, State, and local government employment. Federal general revenues: Equal to amount received from special taxes.
Standards for providers of services	Same as Medicare, but with additional requirements: Hospitals cannot refuse staff privileges to qualified physicians. Skilled nursing facilities must be affiliated with hospital which would take responsibility for quality of medical services in home. Physicians must meet national standards; major surgery performed only by qualified specialists. All providers: Records subject to review by regional office. Can be directed to add or reduce services and to provide services in a new location.
Reimbursement of providers of services	National health budget established and funds allocated, by type of medical services, to regions and local areas. Hospitals and nursing homes: Annual predetermined budget, based on reasonable cost. Physicians, dentists, and other professionals: Methods available are fee-for-service based on fee schedule, per capita payment for persons enrolled, and (by agreement) full- or part-time salary. Payments for fee-for-service may be reduced if payments exceed allocation. Health maintenance organizations: Per capita payment for all services (or budget for institutional services). Can retain all or part of savings.
Delivery and resources	Health planning: DHEW responsible for health planning, in cooperation with State planning agencies. Priority to be given to development of comprehensive care on ambulatory basis. Health resources development fund: Will receive, ultimately, 5 percent of total income of program, to be used for improving delivery of health care and increasing health resources. Health maintenance organizations: Grants for development, loans for construction, and payments to offset operating deficits. Manpower training: Grants to schools and allowances to students for training of physicians for general practice and shortage specialties, other health occupations, and development of new kinds of health personnel. Personal care services: Demonstration projects to provide personal care in the home, including homemaker, laundry, meals-on-wheels, transportation, and shopping services.

Mainly public--DINGELL BILL

Subject	Provisions
General concept and approach----------	Program providing health benefits, administered at Federal, State, and local levels and financed by payroll taxes.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	Benefits with no cost sharing or limitations, except as noted. Institutional services: Hospital: 60 days of care. Personal services: Physicians. Dentists. Home health services. Laboratory and X-ray. Other health professionals. Other services and supplies: Medical appliances and eyeglasses. Prescription drugs: Unusually expensive drugs. Specified benefits may be delayed in a State if resources are inadequate.
Administration----------	Federal Government: Special board in DHEW with overall supervision of program. State: Under contract with Federal Government, would establish State plan to operate program at the local level.
Relationship to other Government programs--	Medicare: Continues to operate, but study to be made of methods of incorporating it into the national plan. Medicaid and other assistance programs: Would not pay for services under the national plan. Other programs: Most not affected.
Financing----------	Tax on wage and self-employment income similar to social security tax. Total tax for employers and employees combined would be 4 percent.
Standards for providers of services--------	Must meet State standards. If no State standards, they would be established by national board.
Reimbursement of providers of services-----	Hospitals and other institutions: Reasonable cost of services, but subject to a maximum rate. Physicians and other professionals: Fee for service (based on fee schedule), per capita (for persons enrolled with a practitioner), or salary.
Delivery and resources----------	Grants to students and educational institutions for training in health occupations.

Mainly public--YOUNG BILL

Subject	Provisions
General concept and approach	A program administered by the Federal Government and financed by special taxes on earned and unearned income.
Coverage of the population	All U.S. residents.
Benefit structure	No limits on benefits, except where indicated. No cost sharing for the patient. Institutional services: Hospital inpatient and outpatient. Skilled nursing facilities: 180 days per year. Personal services: Physicians. Dentists. Laboratory and X-ray. Home health services: 180 visits per year. Health exams, maternity care, and well-child care. Other services and supplies: Prescription drugs: For specified conditions. Medical supplies and equipment. Eyeglasses and hearing aids (and eye and ear exams).
Administration	Administered by an independent SSA in manner similar to Medicare program.
Relationship to other Government programs	Medicare and Medicaid abolished. Other programs: Most not affected.
Financing	Special taxes: On payroll (2% for employee and 6% for employer), self-employment (5%), unearned income (5%), and SSI and AFDC payments (2% for recipient and 6% for government). Income subject to tax: Total income (no earnings base). Employment subject to tax: Workers under social security and Federal, State, and local employment. Tax credits: For individuals, one-half of contributions to a maximum of $250 for individual returns and $500 for joint returns. For employers, one-half of contributions to a maximum of $750 per employee. Federal excise taxes on alcohol, tobacco, and firearms would be diverted to, and earmarked for, the program.
Standards for providers of services	Standards similar to Medicare. Major surgery and other specialized services only covered on referral and when performed by a qualified specialist.
Reimbursement of providers of services	Institutions: Reimbursed according to prospective payment methods to be developed by SSA. Practitioners: Fee schedule approved by SSA.
Delivery and resources	Regulation of providers: Services, facilities, and capital expenditures of institutions must be approved by State and local planning agencies. Professional Standards Review Organization (PSRO): Applies to all services under program. Health resources development: 1% of receipts of program allocated to help finance costs of health facility construction authorized under title 16 of the Public Health Service Act.

Mainly public--KETCHUM-LAGOMARSINO BILL

Subject	Provisions
General concept and approach----------	A national program administered by the Federal Government, permitting coverage on a voluntary basis, and financed by enrollee premiums and Federal general revenues.
Coverage of the population----------	All U.S. residents could voluntarily enroll. Employers could voluntarily enroll their employees.
Benefit structure----------	Following benefits, with no limits on amount of services and no cost sharing by the patient. Institutional services: Hospitals, nursing homes, alcohol and drug centers. Physicians services (including psychiatric) and diagnostic services.
Administration----------	Administered by new independent Federal agency.
Relationship to other Government programs--	Federal funding would be terminated under Medicare and Medicaid for services covered by new program.
Financing----------	Premium contributions (including employer contributions, if any): $15 monthly for each adult and $7.50 for child. Premiums reduced for families with income under $10,000. Federal general revenues: Amount equal to premiums collected. Funds allocated as follows: 67% for hospital benefits, 30% for medical benefits, and 3% for administrative costs.
Standards for providers of services--------	Providers of service must be approved by the administering agency.
Reimbursement of providers of services-----	Hospitals: Per diem rates based on hospital's financial statements and projected budget. Physicians: Fee schedule based on usual, customary and reasonable fees in area, established after consultation with medical society. Physicians may charge more than scheduled amount, but must disclose extra fee in advance to patient and report it to the agency. Consolidated payments: Claim forms designed for computer processing and audit. Providers receive monthly consolidated payments.
Delivery and resources----------	Malpractice claims: Must be submitted to arbitration board whose decision could be appealed to courts. Capital expenditures of hospitals: Must be approved by agency to be recognized for reimbursement. Utilization review: Agency would contract with medical societies or PSRO's to assist with or conduct utilization review. Where provider guilty of abuses, payments could be reduced or suspended, or provider excluded from program.

Tax credits--FULTON BILL

Subject	Provisions	
General concept and approach	A 2-part plan including (1) a plan requiring employers to offer private health insurance to employees and (2) a plan making available private insurance for the nonemployed and self-employed, with Federal subsidies of the premium provided through tax credits or subsidy certificates. Supported by American Medical Association.	
Coverage of the population	Employee plan: Full-time employees of private employers and of Federal, State, and local governments (including persons under Medicare) and workers receiving unemployment insurance.	Plan for nonemployed and self-employed: Low-income families, self-employed, and all others not under an employee plan (including persons under Medicare).
Benefit structure	No limits on benefits, except where indicated: Institutional services: Hospital inpatient and outpatient. Skilled nursing facilities: 100 days. Personal services: Physicians services. Dental care: Initially for children age 2-6, later extended to age 17. Home health services. Laboratory and X-ray. Health exams, maternity care, and well-child care. Other services and supplies: Medical supplies and equipment. Cost sharing: 20% coinsurance, with maximum limit of $1,500 for individuals and $2,000 for families; cost sharing reduced or eliminated for low-income and unemployed families. Medicare beneficiaries: Same benefit coverage, but policy excludes the benefits provided by Medicare.	
Administration	Insurance provided through private carriers, supervised by the States under regulations issued by a new Federal board.	
	Employers purchase insurance from carriers.	Family purchases insurance from carriers.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid: Would not pay for covered services.	
Financing	Employee-employer premium payments, with employer paying at least 65% of cost. Special maximum limit on amount of premium costs for small employers. Federal subsidies for all employers with large increases in payroll costs. Premium for unemployed persons paid by Federal Government.	Federal subsidy of premium ranging from 100% to 10% of premium costs, varied according to annual tax payment of family; this subsidy is taken as income tax credit or by obtaining a subsidy certificate from DHEW. State insurance pools established to assure coverage.
Standards for providers of services	Standards could be issued by a new Federal board.	
Reimbursement of providers of services	Hospitals: Reimbursement determined by State governments, based on prospective payment or other methods. Physicians: Payment on basis of usual and customary or reasonable charges.	
Delivery and resources	Studies to be conducted by new Federal board.	

Tax credits--DOWNING BILL

Subject	Provisions
General concept and approach	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance providing specified benefits. Also, would require employers to provide qualified policies to retain favorable tax treatment.
Coverage of the population	All U.S. residents, on voluntary basis.
Benefit structure	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Skilled nursing facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Dental care: Initially for children age 2-6. Later extended up to age 17. Home health services: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Other services and supplies: Ambulance services: 20 percent coinsurance. Catastrophic coverage: Unlimited hospital days, an additional 30 days in a skilled nursing facility, prosthetic devices, and blood (after 3 pints) covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance for physicians, laboratory and X-ray combined limited to $100 per family; separate limit of $100 for hospital outpatient, home health, and ambulance; and separate limit of $100 for dental care. Medicaid program would pay all cost sharing for cash assistance recipients.
Administration	Private insurance carriers issue health insurance policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. A new Federal board establishes standards for program.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services	No provisions.
Reimbursement of providers of services	Usual and customary charges.
Delivery and resources	No provisions.

Tax credits--BENNETT BILL

Subject	Provisions
General concept and approach----------	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance prôviding specified benefits. Also would require employers to provide qualified policies to retain favorable tax treatment.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Extended-care facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Catastrophic coverage: Additional hospital days, 30 nursing facility days, and prosthetic devices covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance (for physicians, laboratory and X-ray) limited to $100 per family. Additional limit of $100 for hospital outpatient services.
Administration----------	Private insurance carriers issue policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. The new Federal board establishes standards for program.
Relationship to other Government programs--	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing----------	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services--------	No provisions.
Reimbursement of providers of services-----	Usual and customary charges.
Delivery and resources----------	No provisions.

Tax credits--BROCK BILL

Subject	Provisions
General concept and approach----------	The proposal would provide tax credits against personal income taxes when medical expenses exceeded a specified percent of family income.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	The credit against income taxes would be payable if medical expenses exceeded 15 percent of modified adjusted gross income. The credit would be equal to 85 percent of the excess amount. Adjusted gross income would be modified by subtracting the amount of personal exemptions ($750 for each exemption) and adding certain excluded capital gains and interest income. The definition of medical expenses would be similar to that used for the present medical expense income tax deduction.
Administration----------	Persons would be required to file an income tax return. The full amount of the tax credit would always be payable without regard to the amount (if any) of taxes.
Relationship to other Government programs---	The President would study the possibilities of ending, reducing, or changing the Medicare, Medicaid, and other Federal programs.
Financing----------	The proposal would be financed from Federal general revenues. The present medical expense deduction would be repealed.
Standards for providers of services---------	No provisions.
Reimbursement of providers of services------	No provisions.
Delivery and resources----------	No provisions.

Tax credits--CLAWSON BILL

Subject	Provisions
General concept and approach----------	The proposal would provide tax credits and revised medical deductions in connection with health insurance and expenses.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	The taxpayer could take a tax credit against personal income taxes equal to 100% of the premium cost of private health insurance. The full tax credit would always be payable without regard to the amount of taxes (if any). The present medical expense deduction would be revised to include medical expenses which exceed $500 in the year for all taxpayers. The definition of medical expenses for both the tax credit and tax deduction would be the same as under present law.
Administration----------	Person would be required to file an income tax return to claim credits or deductions and the proposal would be administered through the tax system.
Relationship to other Government programs----	The President would study the possibilities of ending, reducing, or changing Medicare, Medicaid, and other Federal medical programs.
Financing----------	The proposal would be financed from Federal general revenues.
Standards for providers of services----------	No provisions.
Reimbursement of providers of services-------	No provisions.
Delivery and resources----------	No provisions.

Catastrophic protection--LONG-RIBICOFF--WAGGONNER BILL

Subject	Provisions		
General concept and approach	Proposal includes (1) a catastrophic illness insurance program for the general population provided through a federally administered plan or alternatively under approved private plans and (2) a Federal medical assistance program for the poor and medically indigent. Also includes provisions for Federal certification of qualified private basic health insurance.		
	Catastrophic insurance		Medical Assistance Plan
	Government plan	Private plans	
Coverage of the population	All U.S. residents, except persons under private plans.	Employees (and their families) of employers who voluntarily elect private plan. Self-employed who voluntarily elect.	Without regard to age or employment, low-income families and families qualifying under "spend-down" provisions.
Benefit structure	After person spends 60 days in the hospital, following benefits become available: Additional hospital days, skilled nursing facility (100-day limit), and home health services. After family spends $2,000 on medical expenses, following benefits become available to all members of family: Physicians services, laboratory and X-ray, home health services, medical supplies and appliances. No limit on amount of services (except SNF) and no cost sharing.		No limits on services and no cost sharing except as indicated: Institutional services: Hospital (60 days), skilled nursing and intermediate care facilities. Personal services: Physicians ($3 a visit for first 10 visits), laboratory and X-ray, family planning, maternity, and exams for children. Other: Medical supplies and appliances.
Administration	Similar to Medicare program.	Employers and self-employed purchase approved private insurance from approved carriers. DHEW supervises program.	Similar to Medicare program.
Relationship to other Government programs	Catastrophic benefits payable without regard to coverage under other government programs or private plans. Medical assistance benefits secondary to all other programs and plans. Medicare program continues and Medicaid abolished.		
Financing	Payroll tax of 1% on employers, including Federal, State, and local governments; employers allowed a credit against their Federal income tax of 50% of the tax. Similar provisions for self-employed.	Employers are subject to regular 1% payroll tax, but this tax is reduced by the actuarial value of their private coverage; also receives the 50% tax credit. Similar provisions for self-employed.	Financed by Federal and State general revenues. State share is fixed annual amount based on State cost under Medicaid for types of services under new program, with some additions and subtractions.
Standards for providers of services	Same as Medicare.		
Reimbursement of providers of services	Same as Medicare.	Determined by carrier.	Same as Medicare, but physicians must accept plan's payment as payment in full.
Delivery and resources	Government catastrophic program and medical assistance plan incorporate HMO and PSRO provisions now applicable to Medicare.		
Encouragement of basic insurance	Under provisions designed to encourage improved basic health insurance, DHEW would certify private policies meeting specified standards (including coverage of 60 hospital days and first $2,000 in medical services). States would arrange marketing of this insurance through pools and reinsurance arrangements. DHEW would offer certified insurance in States where not available.		

Catastrophic protection--ROE BILL

Subject	Provisions
General concept and approach----------	Program which would pay medical expenses when they exceed a specified amount. Administered by private insurance companies under State supervision and financed by private premium payments and Federal subsidy.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	All services eligible as medical expense deductions under the income tax law may be covered after family medical expenses exceed a specified amount (the deductible) which varies according to family income and size. There is no deductible for low-income families but the deductible rises rapidly as income increases. Expenses paid by other private insurance or government programs can be counted toward the deductible.
Administration----------	Private insurance carriers would issue and administer the insurance policies. Each State would design and establish a plan. DHEW would establish regulations for the program.
Relationship to other Government programs--	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services covered under the program. Other programs: Most not affected.
Financing----------	Policyholders would pay premium. Premium rate: DHEW would determine actuarial value of policies, but could set a premium rate lower than the actuarial value to encourage widespread enrollment. It would pay carriers (from general revenues) the difference between the actuarial value and the premium rate. Reinsurance: DHEW would arrange a reinsurance mechanism. The carrier would pay the reinsurance premiums.
Standards for providers of services--------	No provisions.
Reimbursement of providers of services-----	No provisions.
Delivery and resources----------	No provisions.

ULLMAN BILL

The "National Health Care Services Reorganization and Financing Act" was introduced by Representative Al Ullman of Oregon as H.R. 1. It is supported by the American Hospital Association.

General Concept and Approach

The proposal would establish a three-part national health insurance program including (1) a plan requiring employers to offer specified private health insurance for their employees and their families, (2) a plan for individuals, and (3) a federally financed plan providing health insurance for aged, low-income, and medically indigent persons administered through Federal contracts with insurance carriers. The benefits of all plans would be the same.

The State governments would have major responsibility for administering the health insurance program and regulating providers of service and insurance carriers, in accordance with Federal rules. The State would also incorporate and regulate a system of health care corporations which would provide (through their own facilities or affiliated providers) health care services to an enrolled population in designated geographical areas.

REQUIRED COVERAGE OF EMPLOYERS

The plan requiring employers to provide specified health insurance coverage for their employees would provide health care services generally subject to cost sharing by the patient. Additional catastrophic benefits would become payable when expenses exceed a specified amount. Coverage would be purchased from private insurance carriers, with the premium cost shared by employers and employees. Federal subsidies and tax deductions would be available under certain circumstances.

Coverage

The coverage requirement would apply to all private employers subject to the social security tax and to all State and local governments, but not to the Federal Government. Employees and members of employee's families who are under Medicare would not be included in the plan (but would be covered under federally contracted insurance, as explained later). Where two or more members of the family are employed (or an individual has more than one employer) coverage would be provided by the employer paying the highest wages.

The participation of employees would be voluntary. Employed persons eligible for an employee-employer plan are not eligible under the federally financed plan (for the aged, low income, and medically indigent) even though they meet the requirements of the Federal plan.

Coverage under the employers plan would be continued for 14 days for employees whose job is involuntarily terminated, but would cease when the employee became eligible for unemployment insurance. Coverage for workers receiving unemployment insurance would be provided through the Federal-State unemployment insurance system. Also, without regard to the cause of termination of employment, coverage would be available at the option of the employee for a period of 30 days, with the employee paying the entire premium.

Self-Employed Persons and Others

Coverage under the proposal would be made available on a voluntary basis at reasonable group rates to self-employed persons and other individuals (not eligible for federally contracted coverage). The arrangements for this coverage would be made by the States in accordance with Federal regulations.

Benefit Structure

The required benefits of the program would be phased in in two stages with the initial benefits effective 6 months after enactment of the bill and the regular ones (referred to as comprehensive health care benefits) 5 years after enactment.

The timing of covered benefits are shown in table 1 and the benefit provision in table 2. The comprehensive health care benefits include catastrophic expense benefits, but the latter are shown in a separate column in table 2 because (as explained later) they would also be applicable to the initial benefits. Approved plans may include additional benefits (or eliminate or reduce the cost sharing) but these are not subject to the requirement or subsidies of the program.

Most benefits are subject to cost-sharing provisions requiring the patient to pay a flat dollar copayment or a percentage of the charges. The amount of the flat copayment would be increased, if the Consumer Price Index for a year rises by 3 percent or more over the previous year, at the same rate as the rise in the price index.

The nature of the health examination benefit, referred to as periodic health evaluation, would be established by regulation. The bill states that consideration be given to providing the following schedule of examinations:

TABLE 1.--ULLMAN BILL: Effective date of benefits

Group	Type of benefits and effective date		
	6 months 1/	3 years 2/	5 years 3/
General population:			
Employees.....	Medicare benefits Catastrophic expense		Comprehensive health care
Self-employed and others.....	Medicare benefits Catastrophic expense		Comprehensive health care
Persons receiving unemployment insurance.....	Medicare benefits Catastrophic expense		Comprehensive health care
Federally contracted insurance:			
Aged.....	Medicare benefits: Automatic coverage under Part B Catastrophic expense for low-income group	Catastrophic expense for all	Comprehensive health care
Low-income.....	Medicare benefits, with no cost sharing		Comprehensive health care
Medically indigent	None	Medicare benefits Catastrophic expense	Comprehensive health care

1/ Effective at the beginning of the first calendar or fiscal year which occurs 6 months after enactment.
2/ Effective at the beginning of the first fiscal year which occurs 3 years after enactment.
3/ Effective at the beginning of the first fiscal year which occurs 5 years after enactment.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefits
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Institutional services						
Hospital inpatient	90 days (plus 60-day lifetime reserve).	Deductible and coinsurance after 60th day.1/	90 days	$5 per day		No cost sharing, no limit on days.
Skilled nursing facility	100 days 2/	Coinsurance after 20th day.1/	30 days	$2.50 per day	Available after hospital stay of 3 days or more.	No cost sharing.
Nursing home	No benefit		90 days	$2.50 per day		No cost sharing.
Outpatient institutional care program	No benefit		3 days substituted for each hospital day	$2 per day	See text	No cost sharing, no limit on days.
Personal services						
Physicians' services: In home, office, and outpatient center	No limit	$60 deductible, 20 percent coinsurance.3/	10 visits per year.4/	$2 per visit.4/		No cost sharing, no limit on visits.
In hospital and other institution	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	$2 per visit.4/	Copayment applies only to attending physician.	No cost sharing.
Diagnostic services	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	20 percent	No cost sharing for enrollees of health care corporations.	No cost sharing.
Health examinations	No benefit		By regulation	None		
Immunizations	No benefit		No limit	None		
Well-baby care	No benefit		(Per year)			
Under age 1			8 visits	None		
Age 1 to 2			4 visits	None		
Age 2 to 5			2 visits	None		

See footnotes at end of table.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits--Continued

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefits
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Personal services--Continued						
Home health services	200 visits 2/	None	200 visits per year.	$2 per visit		No cost sharing.
Dental services (for children):						
Examination and cleaning	No benefit		1 visit per year	None	For children up to age 7; once child is covered, benefits continue to age 12.	No cost sharing.
Other services	No benefit		Routine dental care, by regulation.	20 percent		
Vision services (for children):						
Examination	No benefit		1 visit per year	None	For children up to age 12; includes services of physician or optometrist.	
Eyeglasses	No benefit		1 set per year	20 percent		
Other services and supplies						
Prescription drugs	No benefit		Drugs necessary for specified conditions requiring expensive drug therapy, or especially important to the public health; by regulation.	$1 per prescription.	List of drugs to be shown by generic names.	No cost sharing.
Prosthetic devices	By regulation	$60 deductible, 20 percent coinsurance. 3/	By regulation	20 percent	May include hearing aids.	No cost sharing.
Medical equipment	By regulation	$60 deductible, 20 percent coinsurance. 3/	By regulation	20 percent		No cost sharing.
Ambulance services	No limit	$60 deductible, 20 percent coinsurance. 3/	No limit	20 percent	Only when medically necessary.	No cost sharing.

1/ The Medicare hospital deductible for 1976 is $104. The hospital coinsurance rate after 60 days is one-quarter of the deductible ($26) and, for the lifetime reserve, one-half ($52). For skilled nursing facilities, the rate is one-eighth ($13). The amount of the deductible is raised each year if the per diem cost of inpatient hospital cost increases.

2/ Skilled nursing care and 100 home health visits are provided under Part A after a hospital stay of 3 days or more. Also, 100 home health visits are available under Part B.

3/ The $60 deductible is a common deductible applicable to specified services.

4/ If a single combined change is made for services in and outside the hospital (e.g., for surgery or obstetrical care), the out-of-hospital visits would be exempt from the 10-visit limitation and coinsurance of 10 percent of charges would apply in lieu of the $2 copayment.

Age 5-18.....	One examination every 5 years
Age 19-64.....	One examination every 2 years
Age 65 and over.....	One examination each year

The regulations would also establish the services and diagnostic tests included in the health examination and these could be varied for different age, sex, and other patient groups. Screening tests and examinations would be included, but physical examination by a physician would not, except when indicated by the results of screening tests.

The provisions for physicians services are defined to include services of allied health personnel under the supervision of a physician. Services of chiropractors are covered on the same basis as under the Medicare program.

As under the present Medicare program, services in a skilled nursing facility would be available after a hospital stay of 3 days or more. The covered benefits also include nursing-home care (available without a previous hospital stay) which would provide a less intensive level of care (referred to as health-related custodial care) to patients with an incurable disease who are bedridden, require certain nursing procedures or meet other conditions.

Mental illness, alcoholism, and drug abuse would be covered on the same basis as other illness. Under a special provision, psychoanalysis would be covered under the basic benefits but would be excluded under the catastrophic benefits unless needed for treatment of severe functional disability for which there is no feasible alternative therapy.

The home health benefit would provide three levels of home health care referred to as intensive, intermediate, and basic. The types of services included in each level are defined in the bill.

The outpatient institutional care benefit would provide day care and other part-time services under a program for the rehabilitation of physically disabled persons and for the treatment of mental illness, alcoholism, or drug abuse. The program, which would be designed to lessen the need for inpatient treatment, would be further defined by regulations. Under these regulations, transportation could be covered for physically disabled persons and the copayments could be removed for drug abuse.

Catastrophic Expense Benefits

The catastrophic expense benefits, which become effective after a specified expenditure by the patient for noncovered expenses, would liberalize the conditions applicable to the regular benefits. They would eliminate the cost sharing for all benefits and remove the limits on the number of (1) inpatient hospital days, (2) physicians' home, office, and outpatient visits, (3) outpatient institutional care, and (4) home health care.

The catastrophic benefits would be payable when specified noncovered medical expenses reach a certain total (the expense limit), which varies according to family income and age. The expenses that would be counted in determining this expense limit are (1) premiums paid for an approved health insurance policy, (2) expenses for cost sharing and (3) expenses resulting from the limitation on the number of hospital and SNF days, physicians' home, office, and hospital visits, and outpatient institutional care days. Expenses incurred in the last 3 months of a year could be included in the next year's expense limit.

The family income classes (which are based on family size and income) used in determining eligibility for catastrophic benefits are the same as used in determining eligibility for federally subsidized health insurance (see Appendix). A separate set of expense limits is applicable to families under age 65, and those age 65 and over. For the lowest income class, the expense limit is, in effect, zero and the catastrophic benefit is always in effect. The expense limit for the highest income class is not specified, but is calculated as 10 percent of income. The expense limits are as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$250	$125
3	500	250
4	750	375
5	10 percent of income	

Initial Benefits

The initial benefit provisions would provide the same benefits as the present Medicare program. In addition, catastrophic expense benefits similar to those described above would be provided; they would remove the cost sharing and the limitation on hospital days, applicable to Medicare benefits (tables 1 and 2).

Administration

The employer would purchase private health insurance for his employees from an insurance carrier qualified under the program. Also a health insurance plan must meet certain requirements to be eligible for the 10-percent subsidy available to enrollees of a health care corporation and similar approved organizations. The qualifications and requirements for carriers are described later.

Financing

The employer is required to pay at least 75 percent of the premium cost, and the employee the balance. Employers would receive subsidy payments if their share of the premiums exceeds 4 percent of the average wages paid to employees. The subsidy would be equal to the amount of the excess, for a maximum of 10 employees. The subsidy would be taken in the form of a tax credit against Federal income taxes for the current taxable year. The coverage for persons receiving unemployment insurance would be financed by the Federal Government.

If the employed person met the requirements for coverage under the Federal plan as a member of a low-income or medically indigent family and his employee premium contribution is larger than the premium required under the Federal plan, he would receive a cash refund of his contribution in the amount of the difference. This subsidy would be paid by the Department of Health, Education, and Welfare and financed from Federal general revenues.

The premium for coverage for self-employed and other persons would be paid by the policyholder. A subsidy, in the form of a credit against Federal income taxes for the current taxable year, would be made to persons in this group if the amount of the annual premium was greater than the sum of 10 percent of the premium and 4 percent of adjusted gross income. The amount of the subsidy would be equal to the amount of the excess. An illustration of the effect of this formula at selected income levels, assuming a hypothetical annual premium of $1,000, is shown below.

Adjusted gross income	Formula: Premium - (10% Premium + 4% Income)	Amount of subsidy
$5,000	$1,000 - (100 + 200)	$700
$10,000	$1,000 - (100 + 400)	$500
$15,000	$1,000 - (100 + 600)	$300
$20,000	$1,000 - (100 + 800)	$100
$22,500	$1,000 - (100 + 900)	0

10-Percent Subsidy

Covered employees, self-employed, and other persons would receive a Federal subsidy if the family is (1) registered with a health care corporation or (2) enrolled in another organization providing comprehensive services to a defined population group through open enrollment, approved by the Department of Health, Education, and Welfare. The amount of the subsidy would be 10 percent of the group premium for covered benefits.

Income Tax Deduction

Under present law, persons who itemize their deductions on their individual income tax return may deduct one-half of their premium for private health insurance, up to a maximum of $150, as a medical expense deduction. Under the bill, persons who itemize could take their entire premium contribution for an approved plan as a deduction.

COVERAGE OF AGED, LOW INCOME, AND MEDICALLY INDIGENT

The Federal Government would provide health insurance coverage for the aged, low-income, and medically indigent groups through contracts with insurance carriers. The permanent benefits would be the same as under the required employer plans, although the interim benefits would be phased in differently. The benefits would be financed from the present Medicare payroll tax, Federal general revenues, and premium contributions from the medically indigent.

Coverage

Aged persons (65 and over) would be eligible for Federal coverage without regard to income, and eligibility for low-income and medically indigent individuals and families would be based on family income and size shown as follows:

Income class	Family size and income			
	Single individual	Family of 2	Family of 3	Family of 4 or more
1...	$0-$2,000	$0-$3,000	$0-$4,500	$0-$6,000
2...	2,001- 3,000	3,001- 4,500	4,501- 6,000	6,001- 7,500
3...	3,001- 4,500	4,501- 6,000	6,001- 7,500	7,501- 9,000
4...	4,501- 6,000	6,001- 7,500	7,501- 9,000	9,001-10,500

Note: Families are defined as parents and dependent children under age 19.

The families in class 1 are defined as the low-income group and those in classes 2, 3, and 4 as the medically indigent. The determination of income would be based on the adjusted gross income shown on the income tax return, but specified kinds of income could be included or excluded, as determined by regulation, if they are considered as readily available for living expenses (or not so). Also income could be determined on a more current basis if necessary to prevent hardship.

The dollar amounts shown in the table would be increased, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the index.

Benefit Structure

The federally contracted insurance would provide the same permanent benefits subject to the same conditions as are applicable to employed persons, and these would also begin 5 years after enactment of the bill (tables 1 and 2). The catastrophic benefits would also be payable according to the income class and age; the table of expense limits is repeated as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1.....	0	0
2.....	$250	$125
3.....	500	250
4.....	750	375

Initial Benefits

The initial benefits for the three groups under federally contracted insurance would be phased in, as described below (table 1).

Aged.--Under the present Medicare law, all qualified aged persons are automatically covered for hospital insurance benefits (Part A), but enrollment for supplementary medical insurance (Part B) is voluntary and requires payment of a premium. Under the proposal, beginning 6 months after enactment, all of the aged would automatically be covered under medical insurance and the premium would be eliminated. At this time, the aged who qualify as low-income persons would also receive catastrophic expense coverage (which would eliminate the cost sharing and hospital limitations of the Medicare benefits). Three years after enactment, all of the aged would be eligible for catastrophic expense coverage.

Low income.--Six months after enactment, low-income families would become entitled to the same benefits as provided under the Medicare program, with no cost sharing required (but with the limits on the number of hospital days retained).

Medically indigent.--The medically indigent families would first become eligible for benefits 3 years after enactment, at which time they would receive Medicare benefits supplemented by catastrophic expense coverage.

Financing

The aged and low-income groups would not pay any premium for the Federal coverage. The medically indigent would pay an annual premium, according to their income class, as shown below. The amount of this premium contribution would be raised, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the rise in the index.

	Individual	Family
Class 2.....	$50	$125
Class 3.....	100	250
Class 4.....	150	375

Other Sources of Funds

The payroll tax levied to finance the benefits of the present Medicare program would continue. All additional costs of the program would be appropriated from Federal general revenues.

The amount of general revenue needed to finance the program (including the cost of the federally contracted insurance, the 10-percent subsidy described previously, and the administrative costs of the program) and to establish a 5-percent reserve would be estimated by the Department of Health, Education, and Welfare. The estimate would be based on past experience and expected changes in the cost of services, the number of low-income and medically indigent persons, the utilization of health services, and the amount of contributions from the medically indigent.

The Medicare trust funds would be retained and would receive the proceeds from the Medicare tax and the general revenues applicable to the aged (except the additional cost for their catastrophic coverage). All other funds would be paid directly from general revenues.

Administration

The Federal Government would contract with insurance carriers for health insurance for persons eligible for Federal coverage. The carrier must be one qualified to issue subsidized insurance plans (as explained later) and could include carriers underwriting a health care corporation or a corporation, operating on a capitation basis, acting as its own carrier.

The negotiation of the contract would not necessarily be subject to competitive bidding and other standard Federal contract requirements, but information about the proposed contract would be made available to all carriers. Contracts with more than one carrier could be made to provide coverage in an area. Also, a contract could require a carrier to subcontract the insurance with other carriers, or a contract could be made with a combination of carriers (which have established a joint arrangement or organization for this purpose). The Federal Government could use the State as its agent in negotiating contracts.

Enrollment

The conditions for enrollment under the plan would be prescribed by Federal regulations. Open enrollment periods would be held (which would be concurrent for the various carriers and corporations offering federally contracted plans in an area).

Federal regulation would determine the method of payment of premiums by the medically indigent (which could be direct to the carrier, the State commission, or other methods). As prescribed by regulations, a grace

period of not more than 90 days would apply in event of nonpayment of premiums before the insurance could be terminated, but nonpayment could not result in termination of coverage for persons age 65 and over.

Relationship to Other Government Programs

The Medicare program for the aged would be replaced by the new program. Federal financing for the Medicaid program would eventually be limited to services not covered under the new program, but would remain in effect for various population groups and services during the phasing-in period. Federal regulations would establish a new minimum scope of services required under a State Medicaid program, in lieu of the services required under present law, and these would be designed to supplement the benefits under the proposal.

Federal financial assistance under the Maternal and Child Health Program would be limited to noncovered services for persons covered by federally contracted insurance.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The proposal would place major responsibility for administration of the program, in accordance with Federal regulations, on the State. The major provisions relating to State administration of the program would be presented in the State health care plan which would include the regulations for providers of service and insurance carriers and the provisions for establishment and supervision of a system of health care corporations.

Federal Administration

The primary Federal responsibility for the program would be lodged in a newly created department of health and all health programs of the Department of Health, Education, and Welfare (and certain health programs of other departments) would be transferred to this new department. The department would be responsible for the establishment of Federal regulations, review of State compliance with the program, evaluation of the program, and annual reports to the President.

A national health services advisory council of 20 members, appointed for 4-year terms, would include representatives of providers of services and consumers (with the latter to constitute at least one-half its members). The council would advise the department on policy, including prior review and comment on proposed regulations. It would make an annual report to the department and the Congress. The department would be required to report to Congress its views on recommendations about administration (if not adopted), and on the council's legislative recommendations.

State Administration

State responsibility for the programs would be placed in an independent State health commission, composed of three or five members appointed by the Governor for 6-year terms (with a maximum of two or three members, respectively, from the same political party). Representatives of the health care professions could not constitute a majority of the members. Members would be full-time employees, could not hold a financial interest in a health care provider, and could be removed only for cause.

The commission would be advised by a State advisory council which would include representatives of providers (including health care corporations, other providers, professional organizations and societies, and medical schools) and of consumers, with the latter constituting at least one-half the membership.

State Health Care Plan

The State health care plan would be developed by the commission, in consultation with the advisory council, after giving the general public an opportunity to present its views. The plan would need to be approved by the Federal Government. Disapproval would be subject to a hearing and review by Federal courts.

If the State failed to obtain an approved plan within 3 years after enactment of the bill, the Federal Government could intervene and administer the program in the State. It could also intervene if the approved plan is not properly administered, or is later modified, so that it is no longer in compliance with law.

Federal grants would be available to cover fully the expenses involved in developing a State plan, and to pay the following percentage of the cost of administering the plan:

90 percent for the year before benefits begin
85 percent for the first 2 years of program
75 percent thereafter

Reimbursement of Providers of Service

Under standards indicated in the bill and to be established further by Federal regulation, the States would design the methods of payment to providers of service and review the rates of payment proposed by providers.

The bill states that payments to providers of services must be sufficient to meet the financial requirements of providers to fulfill their responsibilities under the program. The standards for the elements to be

included in payment of institutional providers, to be established by the Federal department of health, must require payment for the following expenses:

1. direct and indirect expenses for patient care, including free service to indigents;

2. expenses of approved education and research programs;

3. expenses related to working capital and interest;

4. price level depreciation for assets (which unlike historical cost depreciation, takes account of rising price levels); and

5. payments related to construction, modernization, and expansion of specified projects in years when expenditures for those projects exceed depreciation charges, provided that the total payments over the lifetime of a project does not exceed the price level depreciation charges payable over its lifetime.

Income from grants, gifts, and endowments to the institution would not be deducted from operating costs, in computing payment rates, except when designated for a specific operation. Unrestricted income from these sources could be deducted from the institution's interest expense but only to the extent interest expense is not exceeded.

In addition, payment rates would include a return on total assets used in providing institutional health services. The rate of return would be established annually by the Federal department of health after consideration of rates of return on investments of comparable risk. The established rate of return would be included in the prospective rates for investor-owned institutions. The established rate would also serve as a basis for developing a rate of return for nonprofit providers which would give recognition to the risk assumed under prospective payment methods.

The bill also indicates that all payment methods for institutions established by the States must:

1. exclude payment for unneeded services and for capital expenditures not approved under a certificate of need issued by the State, and

2. require that charges for physicians' services furnished in institutions which are generally available for all inpatients, such as services of radiologists and pathologists, be included in the institution's charges and not as separate physician services.

Payments for noninstitutional providers including professional and related practitioners would be based on reasonable fees, salaries, or other compensation.

Methods of Reimbursement

After consultation with providers, carriers, and other interested parties, the Federal department of health would establish standards for developing methods of prospective payment to providers. The State commission would establish the payment methods for the State. These methods, which would need to incorporate the standards described above, could include prospective payments on the basis of (1) review of the provider's budget and proposed charges, (2) negotiations between the providers and carriers, (3) a system of target rates for groups of providers, (4) a formula approach based on factors such as cost per admission, and (5) other methods of prospective payment.

The State commission could make available one or more methods of payment. If more than one is made available, a provider could select any one method from among these, and once it has done so, the method could not be changed unless it is approved by the commission. The commission could withdraw available payment methods if too few providers elected it, or if the method does not achieve improved results.

Using the payment method it selected, the provider would submit a proposed schedule of prospective rates for a specified period for approval by the State commission. (These could be rates for separate services or capitation rates.) An approved schedule could not be changed during the specified period unless authorized by the commission based on its finding that (1) the change is necessary because of events which could not be foreseen at the time the schedule was approved and (2) the use of the approved rates would impose severe financial hardship on the provider. Providers dissatisfied with any decisions of the commission could obtain a hearing.

Accounting and Billing

The Federal department of health would establish standards for accounting systems to provide guidance to States in developing uniform Statewide systems. The State would require providers to use its uniform accounting system in preparing budgets, statements, and other financial information.

The Federal department would also establish standards for a national system of reporting and billing. This system would be implemented by the States for providers and carriers within the State.

Reimbursement System

The bill establishes procedures for making payments from carriers and patients to providers of service. The carriers participating in the program would issue a health card to their enrollees to identify them as enrolled in the program and would establish a health card account for each enrollee. These accounts, similar to accounts maintained by credit card organizations, would serve as the vehicle for payments from carriers to providers of service. Unless an account is in default, the carrier would pay the provider through the health card account the full established charge for the service including any cost sharing due from the patient. The carrier would collect the cost sharing from the patient who could pay on credit over a period at interest rates indicated by DHEW regulations. The carrier could not recover from the provider even if the patient failed to pay his cost sharing. Payment would not be made on this basis if an account is in default which is defined as 90 days in arrears (that is, the last payment due has not been made for at least 90 days).

Standards for Participation of Providers

Standards for participation of providers would be established by Federal and State regulations. The minimum Federal standards for various types of providers indicated in the bill are as follows:

(1) hospitals, skilled nursing facilities, and home health agencies must meet the standards of the Medicare program (see Appendix)--as under Medicare, approval by State agencies or accreditation by certain national organizations would be accepted;

(2) skilled nursing facilities would need to be physically a part of, or in the immediate proximity to, a hospital and must be under the supervision of the professional staff of a hospital or have an organized medical staff;

(3) home health services must be furnished by a health care corporation, directly or through an affiliated provider;

(4) the use and qualification of paramedical personnel acting as assistants to physicians and dentists must meet Federal standards and the use of personnel according to these Federal standards can not be further restricted by State law.

Scope and Quality of Service

Providers of service would be required to comply with Federal and State standards concerning (1) the quality and, where applicable, the scope and comprehensiveness of services, (2) the control of the utilization of services, and (3) appraisal of the effectiveness of their services. For these purposes, the provider must establish systems of peer review, medical audit, and other procedures similar to the requirements for health care corporations, described later. The commission would review and approve peer review systems, and review the performance of providers in these matters.

Health Planning and Facilities

The commission would take responsibility for implementation and coordination of health facility planning (1) developed under the State health care plan; (2) State, regional, and local plans under the comprehensive health planning act; and (3) plans under other Federal or State programs.

Construction, modernization, or expansion of health care facilities or services by hospitals, skilled nursing facilities, nursing homes, or other organizations would not be permitted unless authorized by a certificate of need by the commission. This requirement would apply even if the capital funds were obtained from grants, gifts, or endowments.

On request of the Department of Health, Education, and Welfare, the State commission would review and recommend on applications of providers and other organizations for grants and contracts under various Federal laws, and act as its agent in enforcing compliance with Federal requirements.

Enforcement Powers

The commission could take corrective action against a provider of service which failed to fulfill its obligations including suspension of payments for covered benefits, subject to hearing and court review.

Participating providers are prohibited, under penalty of Federal law, from soliciting or taking kickbacks or bribes in connection with covered services, or making rebates of fees or charges for referral of patients.

Regulation of Insurers

The commission would regulate health insurance carriers and approve carriers and insurance plans for participation in the program. Various kinds of organizations could qualify as an approved carrier, including organizations which pay for (or provide) health care on a group basis by contract, agreement, membership, or subscription arrangements; or a health care corporation acting as its own carrier.

The commission would be responsible for regulating the premium rates of carriers issuing qualified private plans under the proposal, but (except

for health care corporations acting as its own carrier) regulation could be delegated to the State insurance department or other agency. Federally contracted plans would not be subject to State regulations.

Qualifications for Subsidized Insurance

An insurance plan, to be eligible for the 10-percent Federal subsidy (available for families enrolled in a health care corporation or similar approved organization), must meet the following requirements:

(1) provide coverage and benefits without regard to health status (such as preexisting conditions), economic status, race, sex, occupation, age, or any conditions indicated in regulations; classification of risks for the purpose of setting different premium rates would be permitted only according to actuarial principles;

(2) provide for coordination of duplicate coverage, as prescribed by Federal regulations;

(3) report to the Federal Government on financial matters, utilization of services, peer review of quality of services and other matter, as required by regulation, and make its records available for inspection;

(4) meet other requirements of the State plan.

Federal insurance contracts would be made only with carriers who are qualified to issue subsidized plans and meet any additional Federal requirements that may be established.

The State would be responsible for providing, by regulation, arrangements to assure all residents of the State an opportunity to obtain coverage. Carriers for federally contracted insurance must participate in a State coverage pool, if requested by the State.

Prospective Regulations

Amendments to the law or new regulations, enacted or issued in a year which would affect the obligations or rights of carriers, would not go into effect until the following contract year (except where mutually agreed).

Confidentiality

The Federal department of health would issue standards, for use by the State commissions, which would limit disclosure of certain information, such as the clinical and financial status of patients, to specifically authorized situations directly related to administration of the program.

Evaluation of the Program

A national uniform statistical program would be established by the Federal Government. Each State commission would function as a center for the collection of health statistics and information, and providers and carriers would be required to report statistical information. (Safeguards would be provided to prevent disclosure of identifying information.)

As prescribed by Federal regulations, the commission would evaluate the health-related and economic effectiveness of its activities, and of health care corporations and other providers. The evaluation would include a comparison of utilization of services for health care corporations and for other providers. The evaluation and other reports required by regulation would be filed with the new department of health. At the Federal level, the department would evaluate the effectiveness of the program.

Disputes and Claims

The commission would settle disputes between individuals, providers, health care corporations, and insurance carriers by providing hearings before it in the following situations:

(1) claims by individuals against a provider or carrier (or vice versa) where the disputed amount is $100 or more;

(2) allegation by an individual of the failure of providers to meet their obligations, where the failure is part of a pattern of similar conduct;

(3) claims by a provider against a carrier for payment of charges for services (or for capitation charges);

(4) disputes between health care corporations and affiliated or nonaffiliated providers.

HEALTH CARE CORPORATIONS

A health care corporation is defined as a nonprofit or governmental organization which is organized to (1) furnish comprehensive and coordinated health services through its own facilities or affiliated providers, (2) conduct related educational, research, and other activities, and (3) provide adequate representation of its enrollees and affiliated providers on its governing board. The provisions and regulations for providers of service described above (and for insurance

carriers where the corporation acts as its own carrier) would apply generally to corporations. Additional and specialized provisions applicable to corporations are described here.

Establishment of Corporations

The State commission would have responsibility for establishing a system of health care corporations in its State. It would assist organizations wishing to establish corporations by providing information, advice, and assistance in applying for Federal grants.

The commission would approve corporations to operate in specified geographical service areas. Service areas need not coincide with existing political boundaries and could extend across State lines, and the commission would assist in arranging with other States to establish joint areas. Organizations submitting applications for approval as a corporation would designate their preferred service area.

Applications for corporations would be evaluated according to the following criteria:

(1) the applicant's organization, management, resources, financial responsibility, and conformance with other requirements;

(2) the need for the proposed services in the area; and

(3) the need for an additional corporation.

If more than one application is pending, the applications would be considered simultaneously. The commission would consult with representatives of the public, providers, and government agencies before approving corporations and their service areas. The commission (or another State agency) would incorporate approved organizations under State law. The initial approvals of corporations must be completed 4 years after enactment of the bill.

Enrollment

Periodic open enrollment periods would be held, with the conditions for enrollment determined by Federal and State regulation. At the start of the enrollment period, the corporation must provide full information to the public about its operations and services. It must enroll all persons living in its service area who apply, and could not discriminate

(in enrollment or in providing services) on the grounds of race, creed, color, national origin, age, sex, occupation, economic status, or conditions of health. The corporation must make reasonable efforts to enroll persons assigned by the commission. An applicant who is not accepted could obtain a hearing before the commission.

Where the capacity of a corporation is limited, enrollment may be limited (with the approval of the commission) on a first-applied basis, but only if other approved corporations are available in the area. With the commission's approval, the corporation could enroll persons living outside its area and others it is not required to enroll. The corporation would assist eligible enrollees to obtain federally contracted coverage.

Medical Services

The bill states that the services of the corporation would, to the extent possible, (1) emphasize health maintenance and health education, (2) assure continuity of care and appropriate referral, (3) provide maximum care on an outpatient basis, (4) make services readily available, and (5) furnish outpatient care in places accessible throughout the area.

The corporation would be required to furnish to its enrollees all the hospital and medical services covered under the insurance provisions of the proposal. Emergency and ambulance services must be made available at all times. The corporation must schedule a periodic health examination for each enrollee.

The corporation would also be required to provide health education services designed to encourage healthful living and proper use of services, especially for low-income and medically indigent enrollees, with special assistance given to persons with language or educational handicaps.

A continuing personal health record (including medical histories and other information) would be maintained for each enrollee and be made available to the corporation's staff and affiliated providers (and, for emergency care, to unaffiliated providers). These records would be transferred when a member transfers to another corporation. The health records (which could be used for statistical purposes) could not be disclosed without the enrollee's permission, except when necessary for the administration of the program.

The corporation would be required to give emergency services to persons not enrolled with it and, if resources are available, could provide other services to nonenrollees.

Method of Providing Services

The corporation could provide services directly through its own facilities and personnel, or through affiliated providers under contract with it. Affiliated providers could be institutions (hospitals, nursing facilities, or home health agencies) or practitioners (physicians, dentists, podiatrists, or optometrists). An affiliated provider could be a solo practitioner, partnership, clinic, or group practice plan and could be affiliated with more than one corporation (with one affiliation designated as the primary one).

Prescription drugs, medical appliances and equipment, and ambulance services could be furnished by nonaffiliated providers under approved arrangements. Specialized services could be also provided by arrangement with an unaffiliated provider.

Practitioners

Within its needs, the corporation must permit all practitioners to furnish services for it as staff members or affiliated providers. Also, consistent with its type of organization, the corporation must permit practitioners to choose their form of practice. The corporation would determine annually the scope of services that practitioners would be permitted to perform. It could not discriminate in selecting practitioners or determining their services on grounds unrelated to qualifications (but could prefer those located in the service area).

The bill states that medical judgments could be made only by physicians, that medical policies must be established with the advice of physicians, and that the participation of physicians in policy formulation and administration of the corporation should be encouraged. Physicians could not be disqualified, by State law or regulations, from serving on the governing board of a corporation.

Outpatient Centers

Through affiliated providers or other methods, outpatient centers would be established to furnish primary medical care and (to the extent possible) health maintenance services, home health care, medical social services, and well-baby and mental health care. The centers would make arrangements with other corporation facilities for additional diagnostic services and referral and transfer of patients.

Quality of Services

The corporation would be required to comply (for its own and affiliated services) with the general standards, described previously, concerning the quality and comprehensiveness of service, controls on utilization,

and appraisal of the effectiveness of service. It must establish for this purpose, a system of peer review of medical services by a group of physicians (from the corporation and affiliated providers) and require similar review by a staff committee of affiliated hospitals and skilled nursing facilities. The State commission would review and approve the peer review system and evaluate the performance of the corporation.

The qualification of personnel must at least meet standards of professional organizations. The corporation must establish a program of continuing education for physicians, dentists, nurses and, at its option, other professional personnel.

Charges and Reimbursement

Charges of corporations would be approved by the commission, based on the principles and procedures concerning reimbursement described earlier. Corporations would be responsible for justifying the budget and charges of affiliated providers.

Initially, the corporation could charge its enrollees either an annual capitation charge or separate charges for each service, but capitation must be made available to persons who wish to enroll on this basis, beginning 5 years after incorporation. The basic capitation amount would be the same for all enrollees, varied only by family size and composition, but a different rate could apply to federally contracted insurance.

The corporation would be responsible for payment for services given to its enrollees by out-of-area corporations, and emergency services provided by a nonaffiliated provider.

The methods of payment or compensation by the corporation to its staff and affiliated providers would be as mutually agreed. Arrangements between corporations and practitioners (which could be on a capitation, fee-for-service, or other basis) could not be restricted by State law or regulation.

Study of Capital Needs and Financing of Benefits

The national health services advisory council, mentioned above, would make a special study of the capital needs of health care corporations and related organizations to examine methods of replacing traditional sources of capital financing with a national funding program. It would give consideration to establishing a national trust fund financed from health insurance premiums, a tax on these premiums, appropriated funds,

or other public or private sources. It would also give consideration to the use of special taxing mechanisms, such as a value-added tax or tax credits, as a means of financing comprehensive benefits for beneficiaries of the program.

Other Activities

Manpower.--Corporations would coordinate personnel needs for itself and affiliated providers, conduct in-service training, and encourage the use of physicians' assistants and other paramedical personnel.

Records and reports.--Corporations would be responsible for keeping records and reports (for itself and affiliated providers) on financial matters, utilization of services and results of peer review. These records would be available for inspection by the commission for verification.

Evaluation and research.--Corporations would evaluate their own performance and conduct research on the delivery, quality, and cost of health services which would be made available to State and Federal Governments.

Grievances and Representation

The corporation would be required to establish procedures for handling grievances of enrollees or applicants for enrollment (and maintain records of the grievances for inspection by the State commission) and for settling disputes with affiliated and other providers.

The corporation would establish an advisory committee to represent its enrollees (and additional subcommittees or separate committees to represent groups of members with special interests) and provide other methods to permit its enrollees to express their views on its policies and operations.

Enforcement Powers

If the State commission determines that a corporation is not complying with laws or regulations, it could direct the corporation to correct the situation, take other action such as placing the corporation in receivership, or amend or repeal its approval. These orders or actions would be subject to hearing and court review. Also, other interested parties, such as other corporations and providers, could initiate an action to amend or revoke the approval of a corporation.

Federal Grants

The bill states the policy of the Federal Government to assist in the development of health care corporations, especially in poverty and rural areas, and appropriates, to the extent needed, funds for financial assistance to corporations as follows:

(1) grants for planning and development of corporations;

(2) grants for new or expanded outpatient care centers and home health care agencies (also available to nonproprietory providers affiliated with corporations);

(3) grants for medical equipment, data processing systems, and central-service equipment needed for initial operations; and

(4) contracts to pay the operating deficit of new or expanded corporations for a reasonable period.

In providing financial assistance, the Federal Government would consider the resources availability in various geographical areas and attempt to provide an equitable distribution of assistance. A maximum of 15 percent of the funds could be granted in any one State. For the first 5 years of the program, priority would be given to corporations operating on, converting to, or planning to convert to, a capitation basis and thereafter only to such corporations. Applications for financial assistance must be approved by the State commission.

In addition, the bill directs all Federal agencies providing financial assistance in the field of health care (such as construction of facilities) to use their funds to further the new program, and to give priority to health care corporations, especially those in poverty areas.

BURLESON-MCINTYRE BILL

The "National Health Care Act of 1975" was introduced by Representative Omar Burleson of Texas as H.R. 5990 and Senator Thomas J. McIntyre of New Hampshire as S. 1438. It is supported by the Health Insurance Association of America.

General Concept and Approach

The bill provides three voluntary health insurance plans to make coverage available to the entire population. The plans include: (1) an employee-employer plan, (2) an individual plan, and (3) a plan for the poor. All plans would provide for coverage of medical care services, with benefits generally subject to cost sharing by the patient. Also, all plans would be administered through private insurance carriers and supervised by the State and Federal Governments. The employee-employer plan and the individual health plan would be financed by premium contributions, and contributors would receive tax advantages. The plan for the poor would be financed mainly by Federal and State general revenues. The bill includes provisions designed to increase the supply of health manpower, the development of ambulatory care centers, the expansion of health planning, and the improvement of cost controls.

EMPLOYEE HEALTH CARE PLAN

The employee health care plan would, through use of the tax mechanism, encourage employers to provide qualified health insurance plans with specified benefits for employees and their dependents. Private insurance carriers would collect the premiums and process the claims for benefits. The premiums would be paid by the employer and employees. The plan would be supervised by State insurance departments. The Federal Government would determine the status of a plan under the tax laws.

Coverage of the Population

Coverage would be available to employees working for employers who voluntarily establish qualified plans. Coverage under the qualified plan must be offered to persons employed at least 2 calendar months (and those who, on the day employed, had been covered continuously under a qualified employee or State plan for at least 2 months but are no longer eligible for continuation of coverage under that plan) and who are

(a) considered full-time employees, or

(b) not considered full-time employees but are expected to work at least 20 hours a week for at least 20 weeks or have actually met this requirement.

The plan must make coverage available to the employee, the employee's spouse and dependent unmarried children under age 19, or under age 25 if a full-time student.

Coverage would be continued for the employee and his family under the plan for at least--

(1) 2 months after layoff or termination of employment,

(2) 30 months if absent because of illness or disability,

(3) 2 months of coverage for the surviving family in case of the employee's death.

Also, coverage would be continued for a dependent unmarried child beyond age 19, if the child had become totally disabled before age 19, for as long as disabled. The employer would contribute toward the premium the same amount as if the child were under age 19.

If a health plan under a collectively bargained agreement was in effect when the proposed program began, the requirements of the program would not apply to the employer until the agreement expired (but not later than 2 years after the start of the program).

Benefit Structure

The benefits of the program are shown in table 1. Physician services would include the services of nurses and allied health professionals under the direction of a physician. The outpatient mental health benefit would cover services of a physician or services rendered by a community mental health center. The home health care services would be available only after a hospital stay of at least 3 days.

Services could be subject to a deductible of $100 per person and to coinsurance of 20 percent, except that mental health services and "other dental services" could be subject to 50 percent coinsurance. The maximum cost sharing for a family in a year would be limited to an amount of 10 times the deductible, or $1,000. Covered expenses incurred and applied toward the deductible during the last 3 months of a year would also count toward the deductible for the next year. Eight years after the start of the program, the covered services would be divided into two categories. Category I services would continue to be subject to cost sharing, but Category II services would be exempt from cost sharing.

TABLE 1.--BURLESON--McINTYRE BILL: Services covered by the proposal

Service	Provisions	
	Category I	Category II (no cost sharing) 1/
Institutional services		
Hospital inpatient	No limit	.....
Skilled nursing facility	180 days	.....
Personal services		
Physicians' services	No limit	.....
Hospital outpatient	No limit	.....
Laboratory and X-ray	No limit	All services.
Home health services	270 visits	.....
Mental health services	20 visits	.....
Outpatient physical and speech therapy	No limit	.....
Health examinations	Under age 5, no limit; age 5 and over, 1 exam every 5 years.	Under age 5.
Dental services:		
Examinations	No limit	Under age 13, 1 exam per year.
Treatment2/	No limit	.....
Vision services:		
Examinations	Under age 13, 1 exam per year; age 13 and over, 1 exam every 3 years.	Under age 13, 1 exam. per year.
Eyeglasses	Under age 19, 1 pair every 3 years.	.....
Hearing services:		
Examinations	1 every 3 years	.....
Hearing aids	Under age 19, 1 every 3 years; age 19 and over, 1 per lifetime.	.....
Family planning:		
Physicians' services	No limit	All services.
Contraceptive devices	No limit	.....
Other services and supplies		
Prescription drugs	No limit	.....
Prosthetic devices	No limit	.....
Medical supplies and equipment	No limit	.....

1/ Beginning 8 years after the start of the program, these services would be exempt from cost sharing.

2/ These services would include routine fillings and extractions, oral surgery for removal of impacted teeth and tooth roots, and other dental services; excludes orthodontia.

Beginning in the second year of the program, the deductible would be increased each January at the same rate as the increase in the Consumers Price Index (measured during a base period of the 12 months ending in July of the preceding year) and the family maximum limit on cost sharing would be raised accordingly.

The plan may provide services in addition to those required under a qualified policy and may reduce or eliminate the deductibles and coinsurance.

Administration

The employer may provide a qualified plan by purchasing a health insurance policy, obtaining coverage from an approved health maintenance organization (HMO), providing an uninsured arrangement for medical care, or a combination of these. The plan must be approved by the State insurance department as satisfying the requirements for a qualified plan. The Department of the Treasury may accept the approval of the State insurance department in determining the tax status of the premiums for income tax purposes.

Under provisions designed to protect against insolvency, carriers underwriting insurance under the program are required to have a combined capital and surplus of $1.5 million or 2 percent of premium income for the previous year, whichever is greater. As an alternative, the requirement can be met by securing a performance bond or contracting with another carrier to assure continued coverage in event of failure.

In addition, companies are required to maintain a "NHI contingency reserve" equal to its current liabilities for claims and related expenses, plus 12-1/2 percent of the amount of claims paid in the previous year, up to a maximum of $25 million. The companies must file annually with the State insurance commission a statement of its NHI reserves and its financial condition. A company not meeting the requirements would be considered "impaired." Such a company must meet special conditions and submit a plan to the insurance commission for meeting its obligations and, if this plan is disapproved, an additional plan for review by a special committee of representatives of the insurance industry. This committee may decide that an assessment on other participating carriers is necessary to raise the necessary funds and, if so, the assessment would be made on a State basis, charged separately to either commercial insurers or Blue Cross-Blue Shield insurers (depending on which type of insurer has failed).

Financing

The premiums for an employee plan would be paid by employers to the insurance carrier. As arranged between employers and employees, the employees may be required, without limitation on the amount, to contribute to the premiums, except that the amount of the employee's contribution would be limited to 10 percent of his monthly wages over the following amounts:

Individual.....	$167
Family, with one dependent.....	250
Family, with two or more dependents.....	333

For example, the maximum contribution for an employee with one dependent earning $300 monthly would be $5 (10 percent of $50).

Under present law, an employer may take the full cost of his premium contributions for health insurance as a business deduction for tax purposes. Under the bill unless an employer has a qualified plan, the premium cost would not be an allowable deduction, beginning in the third year after enactment of the bill (in the first year, 50 percent would be deductible and in the second, 25 percent).

In addition, under the present income tax law, employees and other persons who itemize their deductions on their individual income tax returns may deduct one-half of the premiums for private health insurance up to a maximum of $150, with the remainder deductible only to the extent that total medical expenses exceed 3 percent of adjusted gross income. Under the proposal, the employees who itemize may take their entire contributions toward a qualified plan as a medical expense deduction.

INDIVIDUAL HEALTH CARE PLAN

The individual health care plan would provide income tax incentives to encourage the purchase of individual (nongroup) qualified insurance providing specified health insurance benefits. The premiums would be paid by the policyholder. The State and Federal Governments would have supervisory responsibilities similar to those under the employee plan.

Coverage of the Population

All persons would be eligible to voluntarily purchase a qualified individual health care policy for themselves and their families. This plan would make qualified insurance available to self-employed persons and others not eligible under the employee or State plans.

Benefit Structure

The health care benefits under an individual policy would be the same as under the employee plan. The policy could include benefits in addition to those required under a qualified policy.

The insurance policy must be renewable, but the insurance carrier could, upon due notice, choose not to renew all its qualified individual policies in the State, or could adjust the premium rates for a class of policies according to the experience for that class. Coverage under the policy ends when the policyholder becomes covered under another type of qualified policy or becomes eligible for Medicare benefits.

Administration

Persons would purchase the insurance from a private insurance carrier. Policies must be approved by the State insurance department as being qualified and the Treasury Department may accept this approval in determining the tax deductibility of the premium cost. The provisions regarding insolvency also apply to individual policies.

Financing

The policyholder would pay the entire premium cost to the insurance carrier.

Persons purchasing a qualified individual policy may, if they itemize their deductions on their personal income tax return, take the entire premium cost as a medical expense deduction (as explained previously for employee contributions toward a plan).

STATE HEALTH CARE PLAN

The State health care plan is designed to provide the standard benefits for the needy and certain others. It would be administered by a private insurance carrier (or group of carriers) in each State and financed by premium payments from covered persons and contributions from State and Federal general revenues.

Coverage of the Population

Coverage under the State health care plan would be available only to persons not eligible under a qualified employee plan.

(1) Needy persons. -- Individuals and families could enroll in the State plan if their adjusted gross income for income tax purposes was less than the following annual amounts:

Family of one	$ 5,000
Family of two	7,500
Family of three or more	10,000

Eligibility could also be met on a monthly basis, if monthly income for each of the last 2 months was below the following amounts:

Family of one	$416
Family of two	625
Family of three or more	833

The income limits would be increased at the same rate as the increase in the Consumers Price Index. A change would be made whenever the rate of increase, rounded to the lower 10 percent, justified a 10-percent increase.

Persons receiving benefits under a public cash assistance program financed in whole or part by Federal funds would be eligible without regard to actual income. This would include, for example, persons under the Federal supplementary security income program (SSI) and the Federal-State program of aid to families with dependent children (AFDC).

Coverage under the program would continue for persons who become ineligible, as follows:

(a) for families eligible on the basis of the annual income test, for the balance of the policy year;

(b) for families eligible under the monthly test, until the end of the month after the month the family becomes ineligible; and

(c) for persons eligible as recipients of cash assistance programs, until the end of the third month after the month they became ineligible for cash assistance.

(2) Special groups. -- Groups of persons who are receiving substantially all their medical care under a Federal or State program may be enrolled as a group under the plan. These could include, for example, dependents of servicemen and inmates of an institution. Under this provision (which does not apply to public assistance recipients as a group) the Federal or State Government would pay the entire premium for the group, all of whose members must be enrolled.

Enrollment

Families and individuals may voluntarily enroll by filing application with an administering carrier during an open enrollment period each year. Those becoming eligible later may apply within 30 days of their eligibility. Public assistance cash recipients must be enrolled by the public assistance agency.

If a family required to pay premiums failed to do so, coverage would stop at the beginning of the month for which the premium was due. However, coverage would be reinstated if the family requested it within 30 days and paid all premiums due and an additional charge of $10. Otherwise, the family would be ineligible for the rest of the policy year. It could enroll for the next policy year, but would need to pay an additional $10 charge.

Benefit Structure

Services covered under the State plans would be the same as those under the employee and individual plans. The coinsurance requirements would also be the same, but the deductible would vary from $10 to $90 annually depending on family income and size, as follows:

Deductible	Adjusted gross income by family size		
	1	2	3 or more
$10	Less than $1,000	Less than $1,500	Less than $2,000
20	$1,000-under $1,500	$1,500-under $2,750	$2,000-under $3,000
30	$1,500 " $2,000	$2,750 " $3,000	$3,000 " $4,000
40	$2,000 " $2,500	$3,000 " $3,750	$4,000 " $5,000
50	$2,500 " $3,000	$3,750 " $4,500	$5,000 " $6,000
60	$3,000 " $3,500	$4,000 " $5,250	$6,000 " $7,000
70	$3,500 " $4,000	$5,250 " $6,000	$7,000 " $8,000
80	$4,000 " $4,500	$6,000 " $6,750	$8,000 " $9,000
90	$4,500 " $5,000	$6,750 " $7,500	$9,000 " $10,000

The maximum family limit on cost sharing would be ten times the deductible amount, or a range of $100 to $900. In future years, when the eligibility limits are raised above the amounts shown in the tabulation, the maximum deductible would be raised by $10 for each additional (1) $500 for a one-person family, (2) $750 for a two-person family, and (3) $1,000 for a family of three or more above the initial eligibility limits. The maximum family limits on cost sharing would also be raised accordingly.

The State plan could provide benefits in addition to the standard benefits, but the Federal Government would not share in the cost of additional benefits.

Administration

The State plan would be administered by an insurance carrier under an agreement between a State and the carrier, with the approval of the Department of Health, Education, and Welfare. The administering carrier could be a commercial insurance company, a service benefit organization, or any of several other types. The administering carrier would determine eligibility for enrollment in the plan, collect the premiums and government contributions, process claims for benefits, pay providers of services, and administer the State plan insurance pool. Individuals and families enrolled in the plan would be issued health insurance policies.

The operation of the plan would be under the supervision of the State insurance department, and payment to providers would need to meet the standards of the State cost commission.

At the Federal level, the Department of Health, Education, and Welfare would issue regulations for operation of the plan. These regulations would need to be issued in final form at least 9 months before the policy year to which they apply.

As a condition of receiving Federal Government contributions for the State plan, the State must agree that it will not impose a premium tax or similar tax on the State plan, and that it will levy taxes on health insurance business in the State equally on all carriers.1/

Financing

The State plan would be financed by premium payments of enrolled families, graduated according to income, and by contributions from State and Federal general revenues.

Each year the administering carrier would estimate the full actuarial premium amount, that is, the amount per family needed to fully finance the cost of the program in the State. This premium amount would be based on the benefit experience for the previous year, the expected increase in benefits, the estimated administrative cost, and an allowance

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1/ In many States, Blue Cross and Blue Shield are exempt from premium taxes and other taxes applicable to other carriers.

to pay in full to reinsuring carriers any insurance pool losses for the previous year. It would also include a risk charge in an amount set by a committee of five persons consisting of the State insurance commissioner, the administering carrier, and three qualified actuaries. Separate premium amounts would be established for families of one person, two persons, and three or more persons.

The premium rates determined by the carrier would be reviewed by the Chief Actuary of the Social Security Administration, who could recommend a reduction to the Department of Health, Education, and Welfare. If so, at the request of the State, a hearing would be held before a board of three actuaries appointed by the Department (including one with the concurrence of the State and one with the concurrence of the carrier). If the hearing board determined the premium rates were too high, the Federal contributions to the State plan could be reduced.

Contributions of Policyholders

Some families eligible on the basis of the annual income test would pay a premium based on their adjusted gross income. They would not pay any premium if their income for the year was below the amounts specified below:

Family of one	$2,000
Family of two	3,000
Family of three or more	4,000

Those with income above the specified amounts would pay 10 percent of their income above this limit. For example, a family of three or more with income of $5,000 would pay $100 (10 percent of $1,000) toward the premium. These specified amounts are calculated as a proportion (40 percent) of the maximum annual eligibility limits. When the eligibility limits are raised, the specified amounts would be increased accordingly.

All families eligible on the basis of the monthly income test would pay the flat monthly premium rate shown below. These premium amounts are calculated as a proportion (6 percent) of the maximum monthly income limits and would be increased accordingly when the maximum income limits are raised.

Family of one	$25.00
Family of two	37.50
Family of three or more	50.00

The State and Federal Governments would pay the rest of the full actuarial premiums of the State plan--in effect, the premiums for those who do not contribute and the balance of the premiums for those who pay part. Thus, the plan would receive a full premium for all enrolled families. The Federal share of the total government contribution would be 70 to 90 percent, depending on the per capita income of the State.

State Insurance Pool

The premiums and other income of the plan would be deposited in a State insurance pool from which all benefits and expenses of the plan would be paid. The pool would be reinsured by all health insurance carriers licensed in the State. If the pool suffered a loss in a year, the loss would be borne by the reinsuring carriers up to a specified maximum percent of premiums. This maximum would be established each year by a committee of five persons consisting of the State insurance commissioner, the administering carrier, and three qualified actuaries. (As indicated previously, carriers would later be reimbursed for any losses they have borne.) Any additional loss would be absorbed by the State and Federal Governments according to the sharing formula. If the pool showed a gain, it would be retained by the pool and used to reduce the State's future premium contributions to the pool.

Provisions For the Aged

Persons age 65 and over could be covered under the State plan under special provisions applicable to that group. Aged persons must be enrolled in the voluntary supplementary medical insurance plan (Part B) of Medicare to be eligible for State plan coverage. If their income is above the specified limits, so that they would be required to pay premiums, the amount of the premium would be reduced by the amount of the Part B premium. If their income is below the specified limits, the State would pay the Part B premium on their behalf from State general revenues. The Medicare program would continue to operate and would have initial liability in paying for services.

PROVISIONS AFFECTING ALL PLANS

Relationship to Other Programs and Plans

As indicated, the Medicare program would continue to operate. The Medicaid program would not pay for medical services provided under a State plan, nor for cost sharing required by the plan. Most other government programs would not be affected.

Malpractice

In legal cases against a provider for damages for injury caused by negligence or other fault in furnishing services under the new program or under the Medicare or Medicaid programs, damages would not be awarded for the cost of remedial services for which the injured person is eligible under the program.

No-fault Insurance

Benefits would not be paid for services if the same benefits are payable under a no-fault provision of a liability insurance policy (if the no-fault provision is required by law to be included in the policy).

Standards for Providers of Services

Hospitals, skilled nursing facilities, and home health agencies would have to meet the same standards as under the Medicare program (see Appendix). Health maintenance organizations which furnish health care services to enrollees on a per capita prepayment basis would be required to meet quality standards established by regulation.

Physicians and dentists would have to be legally authorized to render services by the State in which they provide their services. Qualified psychologists would be recognized as practitioners in providing services for mental conditions. To be qualified, the psychologist must be licensed or certified, have a doctoral degree in clinical psychology, and have at least 2 years of supervised experience at a licensed hospital or community mental health center.

Reimbursement of Providers of Services

Each State would establish a health care cost commission (as an agency of the State government) and an advisory council to the commission with representatives of consumers, providers, insurance carriers, and health planners. Payments to institutions (hospitals, skilled nursing facilities, and home health agencies) would be based on prospectively approved rates. Institutions would be required to prepare a budget, based on a standard accounting system, and recommend a schedule of charges which would apply to all patients. Annually the cost commission, following its review of the budgets and proposed charges, would approve or disapprove the rates. If the proposed charges are disapproved, the institution could request a hearing before the advisory council. Afterwards, the commission would render a final decision not subject to further review.

The charges for services would need to be reasonably related to the cost of efficient production of the services. In its review, the commission would take into account economic factors in the area, costs of comparable institutions providing comparable services, capital requirements, and the need for incentives to improve service and institute economies. In reviewing costs associated with capital expenditures, the commission would accept the determination of the health systems agency, established under the 1974 National Health Planning and Resource Development Act, that construction was consistent with the health needs of the area. The commission could approve the use of a single charge for a group of services commonly rendered to a class of patients, or a single all-inclusive daily charge for all inpatient services.

The level of rates approved for different categories of institutions would be reviewed by the Department of Health, Education, and Welfare. If the Department determined the rates for a given category were unjustifiably high in relation to other States, the rates would need to be revised or Federal funds for Medicaid and for the State plan under this proposal would be reduced.

Health maintenance organizations would be paid on the basis of per capita charges, which could not exceed the regular premiums for the plan.

Physicians and Dentists

Payment to physicians, dentists, and other health-care personnel would be based on reasonable charges, taking into account the customary charge of the practitioner and the prevailing charge in his locality. Payment could not exceed the prevailing charge which would be set at the 75th percentile of the distribution of actual charges made for similar services during the previous year.

Payments to providers for reasonable costs or reasonable charges under the Medicare, Medicaid, and maternal and child health programs could not exceed the reasonable cost or charge as determined under the proposal.

State Insurance Pool

The State insurance department would be responsible for establishing an organization (pool) to assure that insurance is available to all individuals and small employment groups. The State would have two options in carrying out this responsibility. It could require carriers to offer qualified insurance to individuals and small groups and arrange for the pool to reinsure contracts issued by the carriers (and at the option of the State also issue its own contracts if requested by the carrier). As an alternative, the State could arrange for the pool to issue its own contracts to individuals and small groups (and at the option of the State also reinsure some contracts issued by carriers).

The pool would issue or reinsure contracts for (1) families who wish to obtain individual (nongroup) insurance and are not eligible for coverage under an employee plan or a State health care plan and (2) employment groups with less than 50 employees. These contracts would provide only the minimum required benefits of the program. Also, the contracts would exclude benefits for any condition diagnosed or treated within 6 months of application for coverage (with time covered under a qualified plan immediately before application counted toward the 6-month period).

A committee of five qualified actuaries would be appointed by the State insurance commission to make the actuarial determinations for the pool and recommend premium rates and charges. At the end of each year, the administering carrier would determine the net gain or net loss for contracts issued and for contracts reinsured by the pool. Net losses would be assessed against carriers in the State in proportion to their business in that State.

Delivery and Resources

Health Maintenance Organizations

Provision is made for health maintenance organizations--organizations which provide health care services to enrollees on a per capita prepayment basis--to participate in the program. A health maintenance organization would have to meet the definition of HMO under the 1973 Health Maintenance Organization Act or be licensed or certified under a State law.

The State plan must make health maintenance organizations available as an option for those enrolled in the plans. Where a family elects HMO coverage, the State plan would pay the HMO an amount equal to the average cost of coverage under the regular plan.

Comprehensive Ambulatory Health Care Centers

The bill includes provisions designed to encourage development of comprehensive ambulatory health care centers. These are facilities (located in or apart from a hospital) that are organized to provide a broad range of ambulatory health services and that have the following services and facilities:

(1) Medical, surgical, and preventive care services, including health education.

(2) Arrangements for treatment at a general hospital and other institutions when inpatient care is needed.

(3) Operating and recovery rooms.

(4) Laboratory and X-ray facilities.

(5) Unified medical records.

(6) Peer review programs.

(7) A plan to use allied health personnel.

Grants, loans, and loan guarantees are authorized for the construction or modernization of centers in areas designated by the State comprehensive health plan, and to pay their operating deficits for the first 3 years of operation. Priority would be given to putting facilities in densely populated areas where none exist. Special project grants are authorized for training personnel to staff the centers.

Health Planning

A health policy board in the Executive Office of the President would be created for the purpose of (a) recommending improvements in the organization, financing, delivery, and quality of health care; (b) recommending guidelines for the allocation of funds for health care; and (c) appraising Federal health programs and recommending procedures for interagency coordination.

Recommendations for legislation or other major changes concerning health matters made by Federal agencies would include a statement on its impact on the Nation's health care, including possible adverse effects, irreversible commitments involved, and possible alternatives to the proposal. Also, each recommendation would be assigned a relative priority by the health policy board.

Health Manpower

The bill expands the student loan provisions of the Public Health Service Act for training in the health professions (physicians, dentists, pharmacists, etc.) by increasing to $5,000 the dollar limit for an academic year for tuition and fees, room and board, supplies, books, and other related costs.

Similar loans are provided for training in the allied health professions, without any dollar limit on the amount of the loan. If the person after graduating is employed full-time in these occupations, 20 percent of the loan may be cancelled each year (up to 50 percent of the total loan). If employed in a shortage area, one-third of the loan may be cancelled each year (up to 100 percent of the total loan). The bill also provides for scholarship grants to students training in allied health professions, covering the full cost of tuition and other student expenses.

Grants are provided to trained health professionals, allied health professionals and nurses for serving in areas of critical need for at least 2 years. These individuals would receive guaranteed income payments equal to 110 percent of the annual median income for persons of comparable education and training, or 110 percent of their own earnings in the previous year, whichever is greater.

Special project grants are provided to schools of medicine, training centers for allied health professionals, and other educational institutions to develop and evaluate curriculums to train and coordinate teams of personnel to staff ambulatory health care centers.

FANNIN BILL

"The National Health Standards Act" was introduced by Senator Paul J. Fannin of Arizona as S. 2644. It is supported by the U.S. Chamber of Commerce.

General Concept and Approach

The proposal would establish a two-part program including (1) an employee health benefits plan requiring employers to offer specified private health insurance to their employees and (2) a federally financed plan operated by the States for low-income families. Both programs would offer the same scope of benefits, although employee plans could provide actuarially equivalent benefits in lieu of those specified. Both plans would include a health maintenance organization (HMO) option and review of services by the Professional Standards Review Organization (PSRO).

HEALTH BENEFITS FOR EMPLOYEES

The employee plan would require employers to offer to full-time and certain part-time employees a health benefits plan implemented through private health insurance or similar methods. The premium cost would be shared by employers and employees. Special insurance pools would be established for small employers and the self-employed.

Coverage

Coverage under an employer health plan must be offered to any employee not under the Medicare program who has been employed for 31 days and is

(a) considered a full-time employee;

(b) not considered a full-time employee but is expected to work at least 20 hours a week for at least 26 weeks during the next year, or has in fact met these work requirements in the past year.

The plan must cover the employee, the employee's spouse, and dependent unmarried children under age 21 (age 23 if a full-time student). However, the coverage of eligible children would continue for as long as they are suffering a covered illness or disability.

The requirement would apply to all employers including Federal, State, and local governments. If an employer-employee agreement providing health benefits is in effect at the start of the new program, the requirements would not apply until the agreement expires. At the option of the employee, coverage under the plan would be continued for 31 days after termination of employment.

Benefits

The required services covered under the plan and the limitations on these services are shown in the following chart:

Benefits	Limitations
Institutional services:	
Hospital inpatient.....	No limit.
Skilled nursing facility.....	By regulation. Available only after hospital stay of at least 3 days.
Personal services:	
Physicians' services.....	No limit.
Laboratory and X-ray.....	No limit.
Outpatient physical therapy services.....	No limit.
Outpatient psychiatric care.....	Benefit limited to 2 visits per week and $20 per visit.
Other services and supplies:	
Prescription drugs.....	No limit.
Medical supplies and appliances..	No limit.
Ambulance services.....	When medically necessary.

These services would be phased in, with the following services required at the start of the program: inpatient hospital care, physicians services for hospital inpatients, surgery wherever performed, and laboratory and X-ray services. All other services would be required beginning 4 years after the start of the program.

Cost Sharing

All benefits would be subject to an annual deductible of $100 per person, with a limit of $200 per family. In addition, the following coinsurance would apply:

(1) Coinsurance for all services (except outpatient psychiatric care and obstetrical care) of 25 percent of the first $10,000 annual expenditures per family, or a maximum of $2,500 of out-of-pocket expenses.

(2) Coinsurance for outpatient psychiatric services of 50 percent of the first $10,000 annually per family, or a maximum of $5,000.

(3) Coinsurance for obstetrical care of 50 percent of charges, but with a maximum payment of $500 per birth.

Benefits Value Equivalency

In lieu of the specified benefits, a plan may provide an alternative benefit package that is actuarially equivalent to the specified benefits. To be actuarially equivalent, the total expected claims cost of the plan must be equal to that of the specified package. Further, the expected claims cost for hospital inpatient care, physicians in-hospital services, outpatient surgical services, and laboratory and X-ray benefits in the alternative package must each equal the cost of the same benefits in the specified plan.

To adopt an actuarially equivalent plan, the employer must obtain a certificate indicating actuarial equivalency from a member of the American Academy of Actuaries (or another actuary designated by the State insurance department) and file the certificate with the insurance department.

Administration

An approved health care plan must be adopted in writing and the employer must inform his employees of its availability. The plan may be provided by insuring with a carrier, on a self-insured basis, or benefits may be provided directly by the employer. All plans must be approved by the State insurance department and plans not insured by a carrier must obtain special approval.

Employers with 25 or more employees are required to offer their employees an option of enrolling in an approved health maintenance organization (HMO) as an alternative to the regular plan, as specified by the provisions of the Health Maintenance Organization Act of 1973.

Insurance carriers who offer qualified employee health care plans are required to develop special plans to offer employers with less than 100 employees and to self-employed persons. These special plans may be developed in combination with other carriers and the bill suspends any antitrust laws which would prevent the establishment of insurance pools to provide such special plans.

Compliance

After providing an opportunity for a hearing, the State government could bring court suit against an employer who is not complying with the law. An employer found to have willfully failed to comply could be required to (1) pay a penalty of twice his cost of an approved plan for a maximum period of 2 years and (2) reimburse employees' families for their out-of-pocket payments (or cost of other health insurance) for covered benefits during the past 2 years.

The Department of Health, Education, and Welfare is authorized to issue regulations concerning the employees health benefits program necessary for the efficient administration of the program.

Financing

The employer is required to pay at least 50 percent of the cost of the approved health care plan.

For employees who elect HMO coverage, the employer would pay the HMO an amount equal to his premium cost for insuring his other employees for required benefits. If the HMO charges a higher total premium, the employee can be required to pay the additional amount.

HEALTH BENEFITS FOR LOW-INCOME FAMILIES

This program would provide benefits for families with income below specified levels. The program would be operated by the States using private insurance carriers to administer the plan. Enrollees would pay premiums according to family income, with none required for the lowest income group, and the balance of the cost would be financed by the Federal Government.

Coverage

The maximum family limit for eligibility would vary according to the family size, ranging from $2,809 annually for a one-person family to $9,294 for a seven-person family. The definition of family income would be established by regulations. The maximum limits for each family size are shown in table 1 (which also shows permiums and coinsurance, as discussed later) and can be identified under "50 percent of premium." Each year, the various income limits would be raised according to the rate of increase in the Consumer Price Index during the year.

TABLE 1.--FANNIN BILL: Families eligible for the low-income plan, by family size, premium payable and maximum coinsurance

Family size	No premium	Percent of premium					Maximum coinsurance 1/
		10	20	30	40	50	
	Maximum family income						
1.....	$2,247	$2,359	$2,472	$2,584	$2,696	$2,809	$140
2.....	2,895	3,040	3,184	3,329	3,474	3,619	181
3.....	3,548	3,725	3,903	4,080	4,258	4,435	222
4.....	4,540	4,767	4,994	5,221	5,448	5,675	284
5.....	5,358	5,626	5,894	6,162	6,430	6,698	335
6.....	6,028	6,329	6,631	6,932	7,234	7,535	377
7 or more	7,435	7,807	8,178	8,550	8,922	9,294	465

1/ Maximum coinsurance at the highest eligibility level; the maximum coinsurence would be limited to 5 percent of family income.

Benefits

The types of services covered under the plan would be the same as under the plan for employees but all the services would be provided at the start of the program. There would be no deductibles, and the patient would pay coinsurance of 10 percent of the charges for services, but with the maximum cost sharing limited to 5 percent of annual family income (table 1). For example, a four-person family with income of

$5,675 would pay a maximum of $284. However, this annual ceiling on cost sharing would not apply to outpatient psychiatric care (for which there would be no limit).

Administration

Each State would establish an agency to administer the plan. Families would file for eligibility (in a form established by DHEW regulations) with the State agency which would enroll the family with a State-approved administering carrier. Carriers participating in the employer plan are required to participate in administering insurance for the low-income population. They may do so in combination with other carriers and the bill suspends any antitrust law which prevents insurance pool arrangements among carriers for this purpose. The carriers would issue policies to eligible low-income families and would pay claims for benefits on their behalf.

Enrollees could at their option enroll in an approved HMO in the area.

Financing

Families would pay a premium according to family income. There would be no premium for the lowest income class and other families would pay a premium of 10 percent, 20 percent, 30 percent, 40 percent, or 50 percent of the full premium cost (where family income was more than 105 percent, 110 percent, 115 percent, 120 percent or 125 percent, respectively, of the base income for the lowest income class). The premium required, by family income, is shown in table 1. The balance of the cost would be paid by the Federal Government.

The plan would be financed through State insurance pools, operated by the administering carrier. The pool would receive the premiums, Federal contributions, and other income and pay claims certified by the administering carrier.

An annual experience accounting would be prepared by the administering carrier and submitted to DHEW, the State, and all participating carriers.

All carriers would participate in any pool losses according to a formula designed by the administering carrier and approved by the State. The total losses for a year apportioned to carriers would be limited to 3 percent of premiums, with any excess borne by the Federal Government. If there is a gain, it would be retained in the pool and used to reduce future Federal contributions.

PROVISIONS AFFECTING BOTH PLANS

The provisions of the bill described below would be generally applicable to both plans of the proposal.

Relationship to Other Government Programs

The Medicare program for the aged and disabled would continue. Federal grants for the Medicaid assistance program would be eliminated. Workmen's compensation laws and most other government programs would not be directly affected.

Providers of Service

The conditions for providers of service to participate in the program would be the same as under the present Medicare program.

Professional Standards Review Organization

All services would be subject to review by the Professional Standards Review Organization established by P.L. 92-603 to review the use and quality of services under various health care programs.

Control of Services, Facilities, and Capital Expenditures

The prospective reimbursement rates for institutions, described below, would not allow for costs directly related to facilities and services determined by the local planning agency to be unnecessary.

Institutions must submit to the local planning agency their proposals for additional substantial capital expenditures.

Reimbursement

Hospitals and other institutions would be reimbursed according to prospective budgets with payment rates per specified period of time (e.g., per day) uniform for all patients. Hospital records would be reviewed periodically by a committee representing public and private payors who would analyze the hospital's services, finances, operating and capital budgets, and other relevant information.

Physicians would be reimbursed according to usual and customary charges.

A council of health advisors, consisting of seven members appointed by the President, with the advice and consent of the Senate, would be established in the Executive Office of the President. The council would (1) analyze trends in the health care field, (2) appraise health programs and activities of the Federal Government, and (3) evaluate the quality controls under the new program. It would submit a report annually to the President and to the Congress.

CARTER BILL

"The Comprehensive Health Insurance Act of 1974" was introduced by Representative Tim Lee Carter of Kentucky as H.R. 4747. It is identical to a bill introduced in the 93rd Congress by Representatives Wilbur D. Mills of Arkansas and Herman T. Schneebeli of Pennsylvania as H.R. 12684, and by Senator Bob Packwood of Oregon as S. 2970, that was endorsed by the Administration, except for the coverage of additional preventive care benefits as indicated on p. 95.

General Concept and Approach

The proposal would establish a three-part national program including (1) an employee health care benefits program requiring employers to offer specified private health insurance to their employees, (2) a State-operated assisted health care program providing coverage for low-income families and for families and employment groups who are high medical risks for health insurance, and (3) a Federal health care program for the aged persons, representing in effect an expanded Medicare program. All programs would offer the same scope of health services and provide protection against the costs of catastrophic illness.

The State governments would have major responsibility for the supervision of the employee program, administration of its assisted health insurance program, and the regulation of insurance carriers and providers of health services--all in accordance with Federal guidelines or rules.

The program includes provisions to facilitate enrollment in prepaid practice plans by providing an option for persons under all plans of the proposal to enroll in prepaid plans. Also, a new system of reimbursement of providers of health services would be established under the program.

EMPLOYEE HEALTH CARE INSURANCE PLAN

The employee plan would require employers to make available to their full-time employees a health care benefits plan providing a broad range of hospital, medical, and preventive services and protection against catastrophic illness. Coverage would be implemented through private health insurance and financed through employer and employee premium contributions, with temporary Federal subsidies for firms with unusually high increases in premium costs.

Coverage

Employers with one or more eligible full-time employees--measured by a test of number of weeks and hours of work--would be required to offer coverage and contribute toward the premium for a health care plan covering the employee and his family. To qualify as an eligible full-time employee, the employee must work for (a) at least 25 hours per week for at least 10 weeks or (b) a total of 350 hours, in the preceding 13-week period. Thus, for a new 40-hour-week worker, coverage with full employer contributions would start during the ninth week of employment (that is, after 350 hours of work).

However, if an employer is already providing coverage under these regular provisions, any employee working 25 hours a week could elect coverage (starting in the following week) by paying the full premium himself at the group premium rate.

The law would apply to all employers (as employer is defined by the common law) and would include State and local governments, but not the Federal Government or agencies of foreign governments or international organizations. Employees age 65 and over and aged members of an employee's family would not be eligible under the employee plan. For eligible employees, participation in the plan would be voluntary.

Continuation of Coverage

Coverage under an employee benefit plan, with full employer contributions, would continue for at least 90 days after termination of work. It could continue an additional 90 days, at the option of the employee, with the employee paying the entire premium at the group premium rate. These 180 days of additional coverage would provide protection during periods of unemployment, the beginning period of a new job, and periods of disability.

Benefit Structure

The required benefits under an employee health care plan include hospital, skilled nursing facilities, physicians, home health, and diagnostic services, and such additional benefits as prescription drugs, preventive care, and special services for children.

A plan could not exclude benefits for preexisting medical conditions, require any waiting period before benefits become payable, or impose any maximum limit on the total amount of benefits payable on an annual, lifetime, or any other basis. The required basic benefits are shown in table 1.

TABLE 1.--CARTER BILL: Covered services under the proposal

Type of service	Limit on benefits	Other information
Institutional services		
Hospital inpatient	No limit	Special limitations for mental illness.
Skilled nursing facilities	100 days per year	Available after a hospital stay of 3 days or more.
Personal services		
Physicians' services	No limit	Includes home, office, and hospital visits. Special limitations for mental illness.
Home health services	100 visits per year	----------
Laboratory and X-ray	No limit	----------
Outpatient physical therapy services	No limit	----------
Podiatrist services	No limit	Excludes routine foot care.
Preventive services:		
Family planning services	By regulation	Includes services and supplies.
Prenatal and maternity care	By regulation	----------
Well-child care	By regulation	For children under age 6.
Special services for children:		
Dental services (for children under age 13)	No limit	Routine services including examinations, fillings, extractions and replacements; excludes orthodontia.
Vision services (for children under age 13)	By regulation	Includes eye examinations and eyeglasses.
Hearing services (for children under age 13)	By regulation	Includes examinations and hearing aids.
Other services and supplies		
Prescription drugs	No limit	Includes full range of drugs of kinds available only by prescription, and any additional lifesaving drugs provided by regulation.
Blood and blood products	By regulation	----------
Prosthetic devices	No limit	----------
Medical equipment and supplies	No limit	----------
Ambulance services	By regulation	Only when medically necessary.

Mental Illness

Under special limitations applying to mental illness, inpatient hospital care for mental illness is limited to 30 days in a year. Partial hospitalization (such as day or night care) is specifically covered, with 2 days of partial care substituted for each of the 30 available days of hospital care.

The total amount of benefit payments for outpatient mental illness services would be initially calculated by estimating the total charges for 30 visits to a private practitioner for the treatment of mental illness. (For illustration, 30 visits at say $30 a visit, or $900.)

However, the amount determined by this calculation represents the maximum amount of benefits payable annually for care in an approved comprehensive community care center. For care by a private practitioner or in other settings, the benefits payable would be one-half that maximum amount. (In the illustration above, $450.)

In either case, no limit is set on the actual number of visits in any setting (the reference in the law to 30 visits is given only to provide a basis for calculating the maximum dollar amount of benefits that would be payable).

Cost Sharing

Payment for all covered services, except drugs, would be subject to a common deductible of $150 annually per person (but with no further deductible after three members of a family have met the deductible for the year). Payment for drugs would be subject to a separate deductible of $50 annually per person (without regard to the regular $150 deductible). A separate deductible may be imposed on blood and blood products, by regulation. (There is no separate deductible for inpatient hospital care.)

Payment for all covered services, above the deductibles, would be subject to a coinsurance rate of 25 percent.

The maximum amount of cost sharing (deductibles and coinsurance) would be limited to $1,050 in a year for an individual and $1,500 for a family. Above that amount (referred to as the maximum family liability) all covered services would be provided with no further payment that year by the patient.

These deductibles would be in effect during the first 2 years of the program. Each year thereafter, the amount of the regular deductible would be raised in proportion to the increase in the average cost of the required benefit package. The drug deductible would also be increased so that it would continue to be one-third of the regular deductible.

Cost sharing paid during the year under the three plans of the proposal would be combined and counted toward the annual deductibles and the maximum family liability for cost sharing.

With unlimited hospital and other expensive services covered (including kidney dialysis and transplants) and with a limit on total cost sharing, the employee plan would protect most covered families against the high costs of catastrophic illnesses.

Additional Benefits

An employee health care plan may offer additional services supplementing the required services, reduce or remove any limitation on the amount of these benefits, and reduce or eliminate the cost sharing requirements. Any additional benefits provided would not be subject to the general requirements of the program (except the disclosure requirements, discussed later). The employee is not required to accept (or contribute toward) any additional benefits but could elect only the required benefits of the program.

Administration

The employer must inform his employees of the availability of his plan, its benefits, and its other provisions. He is forbidden by law to require the employee to forego participation in the plan as a condition of employment, to offer financial inducements to do so, or to offer an unapproved plan to his employees. Further, an employer may not discriminate in hiring, or in conditions of employment, because of the employee's health condition or that of his dependents (unless required by the nature of the job).

An employer could meet his obligations to provide an employee health care insurance plan by purchasing a health insurance policy insured by a carrier or providing a self-insured health plan. He could also provide the required health insurance by enrolling his entire employment group in the assisted health care insurance plan, as described later. (The bill also includes special provisions concerning prepaid plans, also described later.)

A recognized union or other bargaining agent could select, on behalf of the employees it represents, the options available on coverage (including choice of plan, decisions on additional coverage, and similar matters).

Any employed member of a family eligible under the coverage provisions of the law could take out a family policy covering the employee and eligible dependents.

Compliance and Approval

The Federal Government may require an employer to provide information concerning his compliance with the law, and could bring suit in Federal court to enforce the coverage and other provisions. An employee could also bring suit against his employer to obtain compliance.

The employee health plan must be approved by the State and the health insurance carriers and providers of service must be qualified under the program, as described later.

Financing

The employer must contribute at least 75 percent of the premium cost of the required health care insurance plan, but 65 percent for the first 3 years of the program. Employees must contribute the balance of the premium for the required insurance coverage.

If the employee elects to accept better coverage offered by his employer plan, he can be required to pay an additional premium. In any case, the contributions for better coverage and in fact the employer contributions (above that required by law) could be arranged or negotiated between employers and employees, as under present arrangements.

Premium rates would be set for an individual policy and for a family policy, with the individual rate being 40 percent of the family rate. No other variations in premium rates by family size or composition would be permitted. A family policy could include the husband and wife, their dependent unmarried children, and dependent parents living in the employee's residence (but not aged persons eligible under the Federal program).

Amount of Premium

The amount of the total premium would be negotiated between the insurance carrier and the employer. In general, the premium rate for large group insurance plans is based on the cost of benefits under the plan, a method of calculating called experience rating. However, experience rating is usually not used for small groups, but rather a variety of other rating methods are used. For firms with very few employees, perhaps just 1 or 2, group rates are often not available.

Under the proposal, all carriers who wish to sell approved coverage to employers with fewer than 50 employees must make coverage available to all such small employers in the State, and must charge them the same individual and family premium rates.

Under the proposal, that part of the premium rate applicable to benefits for persons who incur more than $10,000 annually in covered expenses for required benefits could not be included in the experience rating formula for a particular employer, but must be the same for all of a carrier's approved employee plans in the State (that is, averaged over that carrier's Statewide health insurance business).

The Department of Health, Education, and Welfare (DHEW) has estimated the national average premium rate for a required benefit plan at $600 annually for a family policy and $240 for an individual policy, at 1975 levels.

Federal Subsidy

If, as a result of the requirement to offer coverage, an employer's premium contributions increase his payroll by more than 3 percent, the Federal Government would pay a subsidy covering part of the excess over the 3 percent. The subsidy would be available for the first 5 years of the program, as follows:

Year of program	Percent of excess covered by subsidy
First	75
Second	60
Third	45
Fourth	30
Fifth	15
Sixth	No subsidy

The availability of the subsidy and its amount would be based on an employer's Statewide payroll and premium costs.

ASSISTED HEALTH CARE INSURANCE PLAN

The assisted plan is designed to make health insurance coverage universally available to all persons not otherwise insured against the costs of health care. The plan would be administered by the States through private carriers and financed by premium contributions from covered persons, and from Federal and State general revenues. It would cover the same health services as the employee plan, but with cost sharing and premiums varied according to family income.

Coverage

All individuals and families would be eligible to enroll in the assisted plan except (1) workers eligible for an employee plan with income over

specified levels--namely, $5,250 for an individual and $7,500 for a family--and (2) aged persons eligible under the Federal health care insurance program.

Also, as indicated, an employer could meet his obligations to provide coverage under an employee health care insurance plan by insuring his entire employment group under the assisted plan (but, at relatively high premium rates). A worker in such an employment group under the assisted plan could elect out of the group and enroll in the assisted plan on a personal basis, for himself and his family. As discussed later, the provisions for cost sharing, premiums, and continuation of coverage under the assisted plan differ for workers who are part of an employment group and those enrolling on a personal basis.

While the eligibility provisions are relatively broad, the desirability of electing the assisted plan (as opposed to obtaining coverage under another approved plan or under a private plan) depends on the premium, benefits, and cost sharing provisions of the plan, and on the employment, income, and health characteristics of the persons or groups involved. A discussion of the persons and groups eligible for coverage under the assisted plan who would be expected to elect the plan is given later, after further description of the provisions of the plan.

Continuation of Coverage

As under the employee plan, coverage for workers in employment groups enrolled in the plan could continue for 180 days after termination of employment, with the employer required to contribute toward the premiums for the first 90 days.

Benefits

The health services covered under the assisted plan would be the same as those under the employer plan, but the cost sharing would vary according to family income. For the assisted plan, a family is defined to include the husband and wife, dependent unmarried children, and dependent parents living in the same household (but excluding any aged persons eligible for the Federal program). Family income could include income from all sources, but will be defined by DHEW regulations.

For cost sharing purposes, individuals and families would be classified in five income classes. The highest income class (class 5) consists of individuals with annual incomes of $7,000 and over and families with $10,000 and over. The income limits for the other four classes are calculated as a percentage of the class 5 income (namely, under 100 percent, 75 percent, 50 percent, and 25 percent, respectively). However, all individuals and families in employment groups under the assisted plan would be included in class 5. The income class limits and cost sharing provisions are shown in table 2.

TABLE 2.--CARTER BILL: Assisted Health Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductibles		Coinsurance rate	Maximum family liability	
		Regular	Drug		Percent	Amount
Individuals						
1	0-under $1,750	0	0	10	6	0-under $105
2	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3	3,500-under 5,250	100	50	20	12	420-under 630
4	5,250-under 7,000	150	50	25	15	788-under 1,050
5	7,000 and over	150	50	25	---	$1,050
Families						
1	0-under $2,500	0	0	10	6	0-under $140
2	$2,500-under 5,000	$50	$25	15	9	$225-under 450
3	5,000-under 7,500	100	50	20	12	600-under 900
4	7,500-under 10,000	150	50	25	15	1,125-under 1,500
5	10,000 and over	150	50	25	---	$1,500

Cost Sharing Provisions

The cost sharing provisions for class 5 are the same as for the employee health care insurance plan. For class 4, they are also the same, except that the maximum family liability is limited to 15 percent of income.

For income classes 1, 2, and 3 all of the cost sharing requirements are reduced. The reduction in the deductibles is calculated as a percentage of the maximum deductibles (namely, for classes 1, 2, and 3, the regular deductible is 0, 33, and 67 percent, respectively, of the maximum deductible; for the drug deductible, the corresponding percentages are 0, 50, and 100 percent, respectively). The reduced coinsurance rates and maximum family liability rates (after which no cost sharing is required for any members of the family) are specified in the law (table 2).

The initial income classes would be applicable for the first 2 years of the program. Each year thereafter, the class 5 income limit (called the income class base) would be increased according to the rise during the year in average earnings as shown in social security earnings records, with proportionate increases made in the other income class limits.

The initial cost sharing provisions would also apply during the first 2 years of the program. Each year thereafter, the amount of the maximum deductibles would be increased to the same amounts applicable to the employee plan (rather than based on the assisted plan), and proportionate increases made in the deductibles for the lower income classes.

Cost sharing under all plans of the program would be combined to determine when the deductibles and maximum family liability limits are met.

Administration

The assisted plan would be administered by the States under regulations established by the DHEW. Each State would submit its State assisted health insurance plan (which would include the provisions concerning eligibility, premium amounts, cost sharing requirements, and related matters) to the DHEW which would approve qualified plans and designate the State agency responsible for its administration. The DHEW approval may later be withdrawn if a State plan no longer complies with the law, or is administered in a way which results in noncompliance. If a State plan is not approved or approval is withdrawn, Federal payments would be withheld for the plan, or for the parts of it not in compliance. Disapproval of plans is subject to hearings and review by Federal courts.

The State of residence of eligible persons would be determined under regulations of the DHEW which would be designed to assure that coverage is available for migrant farmworkers and others who frequently move from State to State.

The States would contract with private insurance carriers to act as their agents to administer the insurance provisions of the plan. The carriers would be reimbursed for their administrative costs, but would not underwrite the insurance. Debts resulting from the failure of enrollees to pay premiums or cost sharing would be considered debts to the State rather than to the carrier. The State must assure confidentiality of information held by carriers about persons enrolled with them.

As an alternative, the States could administer the entire program themselves, without carriers, if authorized by the Department.

Financing

The costs of the assisted insurance plan would be financed by premium payments from enrollees, with the balance shared by State and Federal Government general revenues.

In calculating premiums, a two-rate premium structure would be used, as for the employee plan, with the rate for individuals 40 percent of the family rate. The premium rates would be based on the average premium for employee health care insurance plans in the State (rather than on the costs of the assisted plan) with the maximum premium set at 150 percent of the employee-plan premium.

The premium rates for enrollees (not in employment groups) in the plan would be based on their income class, as shown below. The amount of the premiums shown here are based on estimated national averages for 1975, and there would of course be variations among the States.

Income class	Percent of average employee-plan premium	Amount of premium	
		Individual	Family
1.....	0	0	0
2.....	0	0	0
3.....	50	$120	$300
4.....	100	240	600
5.....	150	360	900

For employment groups brought under the assisted plan by the employer, the premium contributions would be the maximum contribution--that is, the rate for class 5. As for employee plans, the employer would be required to pay at least 65 percent, initially, and later 75 percent of the total premium. The employee would pay the balance.

Where an employee has elected the assisted plan in lieu of his employer's health care insurance plan, the employer concerned would contribute to the assisted plan the same premium required under his own plan. The employee would contribute according to his income class.

State Contributions

The amount of the State contribution to the plan in a year would be determined by a formula based on (1) the State's ability to pay as measured by State per capita income compared with national per capita income, (2) the amount of benefits paid for services under the State assisted plan, and (3) the level of State expenditures under Medicaid, in the year before the program becomes effective, for these types of health services covered by the new program. The formula is designed to result in the States paying about one-quarter of the total Federal-State cost of the program, with the proportions varying according to State per capita income. (For the first year of the program, before benefit data under the assisted plan are available, a special formula would be used.)

The State would not be permitted to impose any premium tax on premiums paid under the assisted plan.

Election of Coverage

Table 3 shows the distribution, by employment status, of persons and groups eligible to elect coverage in the assisted plan, and those actually expected to elect it. In this table, the term "employed" refers to workers who meet the requirements for coverage under an employee health care plan. The "not employed" group refers to all other persons, including part-time workers, the self-employed, the nonemployed, and others. The term "high health risk" indicates individuals or families in relatively poor health who could expect to pay the maximum cost sharing under various plans.

Employed persons eligible under an employee health care plan may find it advantageous to elect the assisted plan, rather than their employee plan, depending on their income level, because of the income-related premiums and cost sharing provisions of the assisted plan. If the workers or their family members are in poor health and expect to pay high cost sharing, the assisted plan becomes desirable even at higher income levels.

TABLE 3.--CARTER BILL: Assisted Health Care Plan: Individuals, families, and employment groups, eligible for coverage and expected to elect coverage, by income and risk groups

Group	Eligible for coverage	Expected to elect coverage	
		Average health risk	High health risk
Employed:			
Individuals.....	Under $5,250	Under $3,500	Under $5,250
Families.....	Under 7,500	Under 5,000	Under 7,500
Not employed:			
Individuals.....	All	Under 5,250	All
Families.....	All	Under 7,500	All
Employment groups....	All	None	All

For employment groups, the health status of the group is probably the most important factor, although the relatively high premium rates usually applicable to small groups would also be a consideration.

The nonemployed poor, many of whom are now under the Medicaid assistance program, would receive coverage under the assisted plan on a basis related to their family income.

For the other "not employed" such as the self-employed, disabled persons, and others not part of an employment group, coverage is now available usually only on an individual (nongroup) basis, at considerably higher premium costs than for groups. This factor, as well as income levels and health status, would influence their decision to elect the assisted plan or other coverage.

The data in table 5, which shows the premiums, cost sharing, and maximum liabilities, by income class, for the three plans, may be useful in understanding further the considerations involved in decisions to elect coverage under the assisted plan.

FEDERAL HEALTH CARE INSURANCE PLAN

Like the present Medicare program, the Federal health care insurance plan would cover aged persons insured under social security and be financed mainly by a continuation of the present Medicare payroll taxes and premium payments paid by covered aged persons. The plan would provide the same health services as the other two plans and thus improve the benefits of the present Medicare program. The low-income aged would receive the advantages of reduced cost sharing and premium payments, with these additional costs financed by Federal and State general revenues. The plan would be administered in a manner similar to the present Medicare program.

Coverage

As indicated, like Medicare, the program would cover persons who are insured under the social security program. Under temporary transitional provisions, every citizen (or permanent alien resident) who has reached age 65 in the first year of the program would automatically be covered (blanketed in) under the plan. Also, in following years, eligibility would be extended to additional persons who have specified credits under social security, but not enough to meet the regular Medicare requirements. Under these provisions, a person would need 3 quarters of coverage for each year from the second year of the program up to the year he reaches age 65. (Social security credits acquired at any time would be counted.) The provision would "wash out" when its requirements became the same as the regular requirements for insured status under social security.1/

All Federal, State, and local government employees would become subject to the payroll taxes of the program and get credits toward coverage under the Federal program. The transitional provisions, described here, would of course assist newly covered persons to become insured under the program.

Persons age 65 and over not insured under the Federal plan could enroll under the assisted health care plan and would pay the cost sharing and premiums applicable to the assisted plan. Disabled persons who were brought under Medicare by P.L. 92-603 (H.R. 1) would not be included under the Federal plan, but most of these would be covered by the assisted plan.

1/ Under the regular requirements, a person needs 1 quarter of coverage for each year after 1950 (or if later, the year he attains age 21) up to the year he becomes entitled to benefits. A person who has 10 years (40 quarters) of coverage is fully insured for life.

Benefit Structure

As indicated, the plan for the aged would cover the same health services as the other plans. Each aged person would be treated as an individual (regardless of family status) for cost sharing purposes and would pay the same amounts of cost sharing--amounts generally less than those required for individuals with comparable income under the assisted and employee plans. However, the low-income aged (those in classes 1, 2, and 3) would have the advantages of reduced cost sharing. These cost sharing provisions are shown in table 4. As for other plans, cost sharing under all three plans would be combined for determining when deductibles and maximum liability are met.

Administration

The Federal plan would be administered by the DHEW in a manner similar to the present Medicare program under which the processing of claims is handled by private carriers under contract with the Department, and Medicare taxes are collected by the Internal Revenue Service.

For the Federal plan, determination of income would be tied administratively to the Supplementary Security Income (SSI) program established by P.L. 92-603 (H.R. 1).

Financing

The present Medicare hospital insurance tax levied on wages and self-employment income would be continued at the same tax rate and earnings base as scheduled under present law and, as indicated, would be extended to cover all Federal, State, and local governments and their employees.

Each aged person eligible for the program would be required to enroll as an individual and pay a premium. The premium rate, which would be the same for all persons, would be calculated as an amount equal to 15 percent of the average cost to the program for an aged person in class 4, estimated at about $90 at 1975 levels. However, the low-income aged, in income classes 1 and 2, would pay no premium.

General Revenues

Funds from Federal general revenues would be paid to cover the cost of benefits and related administrative expenses of persons who become eligible under the special transitionally insured provisions, described above. Also, Federal and State general revenues, shared according to the formula used for the assisted plan, would pay the additional costs resulting from the reduced cost sharing for the aged in income classes 1, 2, and 3, and reduced premiums for classes 1 and 2.

TABLE 4.--CARTER BILL: Federal Health Care Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductible		Coinsurance rate	Maximum individual liability	
		Regular	Drug		Percent of income	Amount
Individuals						
1.....	0-under $1,750	0	0	10	6	0-under $105
2.....	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3.....	3,500-under 5,250	100	50	20	12	420-under 630
4.....	5,250 and over	100	50	20	---	$750

All funds would be deposited and paid from a new Federal health care benefits trust fund.

The premium and cost sharing provisions for each of the three plans are summarized in table 5.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The States would have responsibility under Federal rules or guidelines for administration of major parts of the program, including (1) the approval of employee and other related health plans, (2) certification and regulation of providers of service participating in the program, (3) determination of reimbursement rates for providers of service, (4) supervision of the reimbursement system, and (5) regulation of insurance carriers. Generally speaking, these provisions would apply to all three plans of the program.

The DHEW would review the State laws, regulations, and administration relating to these functions and certify States which are qualified under the law. The decision of the Department on certification would be subject to hearing and review by Federal courts. Unless a State is certified, none of the three plans of the proposed program would go into effect in the State (but the present Medicare program would continue there). Further, as indicated later, at the start of the new program, Federal funding for State Medicaid programs would end in all States for the health services covered under the proposed new program.

As one of the requirements for participation, States must permit individuals to bring suit in State courts to compel the State, carriers, employers, and providers to comply with the State laws and requirements.

Approval of Employee Plans

Carriers providing an employee plan are required to file the plan with the State, which must promptly determine if it is qualified. The requirement would apply to all types of employee plans, including carrier-insured and self-insured plans. The States' approval could later be withdrawn if a plan is changed and no longer meets the requirements, or is administered in a manner which results in noncompliance. The carriers and employers concerned would be promptly notified of the qualification status of their plan.

TABLE 5.--CARTER BILL: Premium rates and cost sharing requirements, by type of plan

Income class	Annual income	Amount of premium 1/	Cost sharing requirements (per person)			Maximum family liability 2/	
			Regular deductible	Drug deductible	Coinsurance rate	Percent	Amount
	Employee health care plan						
All individuals.....		$240	$150	$50	25	---	$1,050
All families.....		600	150	50	25	---	1,500
	Assisted health insurance plan						
Individuals							
1.....	0-under $1,750	0	0	0	10	6	0-under $105
2.....	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3.....	3,500-under 5,250	$120	100	50	20	12	420-under 630
4.....	5,250-under 7,000	240	150	50	25	15	788-under 1,050
5.....	7,000 and over	360	150	50	25	---	$1,050
Families							
1.....	0-under $2,500	0	0	0	10	6	0-under $150
2.....	$2,500-under 5,000	0	$50	$25	15	9	$225-under 450
3.....	5,000-under 7,500	$300	100	50	20	12	600-under 900
4.....	7,500-under 10,000	600	150	50	25	15	1,125-under 1,500
5.....	10,000 and over	900	150	50	25	---	$1,500
	Federal plan for the aged 2/						
Individuals							
1.....	0-under $1,750	0	0	0	10	6	0-under $105
2.....	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3.....	3,500-under 5,250	$90	100	50	20	12	420-under 630
4.....	5,250 and over	90	100	50	20	---	$750

1/ Total estimated national average premium at 1975 levels. For employee plan and, in some cases, for assisted plan, the employee and employer would share payment of the premium.

2/ Under Federal plan for the aged, eligible persons would be treated as individuals, regardless of family status.

Certification and Regulation for Providers of Service

Standards for Participation

The standards for participation by providers of service in the new program are similar to those of the present Medicare program. In addition, provision is made for expanded participation of optometrists and dentists who must be legally authorized to practice in their State. Chiropractors are excluded as providers. (See Appendix.)

The law provides for participation of physicians' extenders--including physicians' assistants, nurse practitioners, and similar personnel--in the program, and establishes the following standards for these personnel. The law also indicates additional standards could be set by regulation:

(1) They must perform services under the supervision and control of a physician, or act as his agent, and these services must be related to the supervising physician's type of practice.

(2) They must complete a training program, or pass a certification examination of an appropriate organization, or meet certain proficiency requirements--in all cases, as approved under DHEW regulations.

(3) The charges for their services must be included in the bills of the supervising physician or employing organization.

(4) The performance of the services must be legal under State law.

Disclosure for Providers

Under regulations to be established by the DHEW, providers of service must make available to persons seeking care information on (1) charges for common services, (2) hours of operation and other information about access to services, and (3) any license, accreditation, or certification held by the provider.

Control of Capital Expenditures

The bill incorporates the provisions of P.L. 92-603 (H.R. 1) which requires approval by the State planning agency of substantial capital expenditures in health care facilities. The present law, applicable to Medicare, Medicaid, and certain other federally aided programs, imposes penalties by excluding reimbursement for depreciation and interest from the payment for services provided by the disapproved capital improvement. The bill would greatly strengthen the penalty by eliminating the entire

payment for the services provided by the disapproved capital improvement. This new provision would apply to all plans of the proposed program as well as programs covered by present law.

Professional Standards Review Organization (PSRO)

The proposal incorporates the PSRO provisions of P.L. 92-603 (H.R. 1) for review of the necessity and quality of services under Medicare, Medicaid, and other programs, and extends these PSRO provisions to services under all three plans of the new program.

It also amends the PSRO law to require mandatory review of outpatient services. Under present law, review is only required for inpatient services and is optional for outpatient care. The new requirement would also apply to programs now subject to PSRO.2/

Reimbursement of Providers of Service

The States would establish rates of reimbursement for covered services for the three plans of the program, in accordance with procedures and criteria established by DHEW. These rates would be made publicly available.

Reimbursement System

Persons enrolled in all plans would be issued a health card, to identify them as enrolled under the program, and a health card account would be established for each enrollee. These accounts would be similar to accounts maintained by credit organizations and would serve as the basis for reimbursement of providers of service.

The account would serve as the vehicle for payments from carriers and other sources for reimbursement to providers of service. Providers who are participating in the program would be required to elect as either a full participating or an associate participating provider. All hospitals, skilled nursing facilities, and home health agencies must elect as full participating. The States would certify providers as qualified full or associate providers and make this information publicly available. Individuals could challenge the State certification in State courts.

2/ Unlike the other provisions discussed under this section on administration and regulation of the program, the PSRO provisions would not be a primary responsibility of the State.

Full participating providers must accept the State-established rate for a service as their full charge for patients under all plans of the program. The health card account would pay them the full established rate for their service, including the cost sharing due from the patient. Associate providers must also accept payment on this basis for patients under the assisted plan and the Federal plan for the aged. The account would collect the cost sharing from the patient who could pay on credit over a period and at interest rates indicated by DHEW regulations.

Associate providers could refuse to accept the established rate as full payment for employee-plan patients, and could charge the patient an additional fee or amount above that rate. In this case, the health card account would pay them only the covered (insured) part of the charges, at the established rate, and the provider would need to collect both the cost sharing and the additional fee directly from the patient.

However, an exception is made for pharmacies and other drug providers who, though certified as associate providers, would receive the established rate including the cost sharing from the health card account, and could collect additional charges from the patient. This special provision would apply to persons under all three programs. It would of course be expected that patients would tend to purchase from pharmacies which do not impose any additional charges.

Anti-Duplication

The bill permits coverage only under one approved plan and provides that, if a person is enrolled under more than one plan, only one of the plans would pay for any service, as determined by DHEW regulations.

Regulation of Insurers

The law would permit various types of organizations, including voluntary associations, corporations, and partnerships to qualify as approved health insurance carriers. The organization could be one which pays for or provides health services under group insurance policies, hospital or medical service agreements, or membership or subscription contracts.

Employers who self-insure on a qualified basis, and pay for or provide health services directly for their employees, could also participate as approved carriers.

The States would be required to regulate and enforce the following requirements of the Federal law for carriers of all types, but could impose more stringent requirements if they wished:

(1) The carriers would be required to file with the State a statement of rates or rating formulas (referred to as "file and use" procedures) for each approved employee plan. The statement must include sufficient information to permit the State to determine if the rates are reasonable in relation to the benefits provided and the State could disapprove or suspend rates considered unreasonable.

(2) An annual audit of each carrier must be conducted by a certified public accountant (CPA) and the reports made public.

(3) Upon request, the carrier must disclose to persons to whom a plan is offered, the plan's (a) benefits and exclusions, (b) premium rates, and (c) the percentage of the premiums expected to be paid in benefits.

The States must also determine the adequacy of the carriers financial condition to meet their obligations and, if a carrier is found to be financially insolvent or impaired, must assure that the carriers obligations will be met--by being paid in full, guaranteed, assumed or reinsured. This requirement could be implemented under an insolvency or guarantee fund or other means established or regulated by the State.

Reporting and Evaluation of the Program

The DHEW would establish requirements for reporting of information necessary to enable it to monitor and evaluate the program, as follows:

(1) Employee health care plans are required to maintain uniform statistical methods and procedures and to report information requested by the Department.

(2) States are required to report information requested by the Department concerning the State assisted plan.

(3) States are required to report to the Department on their activities concerning approval of health care plans, establishment of reimbursement rates, certification of providers, and regulation of providers of service and insurance carriers.

Each year the Department would prepare a report to the President, for transmittal to Congress, which would include a summary of its activities concerning the program, appraisal of the adequacy of the program and, if any, recommendations for additional legislation.

Relationship to Other Government Programs

Federal funds for State Medicaid programs would be limited to the following services: (1) intermediate care facilities, (2) skilled nursing facilities for persons age 21 and over, (3) home health services, (4) care in mental institutions for persons under age 21 and over age 65, and (5) medical or remedial care for persons in a medical institution, or needed to reduce the need for such institutionalization. In all cases, covered health services, cost sharing, or premiums under the new program could not be included for Federal matching funds.

The new program would not pay for services covered under workmen's compensation laws. The health insurance program for Federal employees and retirees and the health programs of the Veterans Administration, the Indian Health Services, and other Federal programs for special groups would continue to operate.

PREPAID HEALTH PLANS

The proposal establishes requirements for participation under the program of prepaid health plans and includes special provisions designed to facilitate and encourage enrollment in these plans.

Employee Health Care Plans

All employers required to offer their employees a health care plan must offer a choice of (1) a health care insurance plan, as described earlier in the discussion of employee plans, (2) a group practice prepaid plan, or (3) an individual practice prepaid plan. The need to offer prepaid plans may be waived if they are not available in the community, as decided by DHEW regulations.

To qualify as an employee plan, the prepaid plan must be approved by the State (like other employee plans) and must meet the general requirements for employee plans including continuation of coverage, anti-duplication provisions, a two-rate premium structure, and reporting requirements to DHEW.

For an employee who elects a prepaid plan, the employer is required to contribute at least 75 percent (initially 65 percent) of the premium cost of the required basic health insurance plan (that is, the same amount he contributes toward basic benefits under his employee insurance plan). If the prepaid plan charges a higher premium, the employee can be required to pay the additional amount.

Assisted Plan and Federal Plan for the Aged

Persons eligible under the assisted plan would also have the option of electing coverage under an approved prepaid health plan as an alternative to coverage under the regular State assisted health care insurance plan. If so, the State would pay the prepaid plan a capitation amount equal to the average cost of coverage under the regular State assisted health insurance plan. Any additional premiums charged by the prepaid plan would be paid by the enrollee.

Similarly, persons eligible under the Federal health care insurance plan could enroll in a prepaid plan, in which case the Federal program would pay the prepaid plan a capitation amount equal to the average cost of the Federal program, and the enrollee would pay any additional premium required by the prepaid plan.

Requirements for Prepaid Plans

To be approved under the program, prepaid health plans are required to meet the general requirements of the program and certain special requirements. As a participating provider of service, it must meet the certification standards and regulations applying to providers, described earlier, and, if it acts as its own carrier, any regulations established for them as insurance carriers. In addition, group practice plans must meet the following requirements of the law:

(1) They must provide, or arrange for, all the required health services under the program, but may vary or remove the cost sharing and limitations on these benefits.

(2) The plans must be reimbursed by means of a predetermined (capitation) rate for all their services, except that they may impose copayments as authorized by DHEW regulations.

(3) They must provide physicians' services through physicians who are employees or partners of the plan, or through arrangements with physicians' groups engaged in the coordinated practice of their profession.

(4) The plans must be organized in a manner so that (a) they bear responsibility for the efficient and effective use of health resources, (b) the components affiliated with the plans share that responsibility, and (c) they provide a clear focal point of responsibility.

An individual practice plan must meet the same requirements as a group plan except that physicians' services would be provided through arrangements with physicians practicing on an individual practice basis (rather than as indicated in item 3 above).

ADDITIONAL PREVENTIVE CARE BENEFITS UNDER THE CARTER BILL

The Administration bill provides for coverage of specified preventive services, as indicated in table 1, subject to the regular cost sharing requirements. The Carter bill covers additional preventive services and removes the cost sharing for all preventive care. The bill, which would cover a series of health assessments over the person's lifetime, indicates the types of assessments appropriate at various stages of life; the diagnostic tests, immunizations, and other services associated with these types of assessments; and, in some cases, the frequency of the assessments. The preventive services include maternity and prenatal services, normal infant and high-risk infant care, school-entry assessment at ages 5-6, puberty assessment at ages 12-14, adult-entry assessment at ages 17-19, young-adult assessment at ages 24-26, middle-age assessment at ages 44-46 and every 5 years thereafter, and older age assessment at ages 59-61 and every 2 years thereafter.

STAGGERS BILL

The "National Comprehensive Health Benefits Act of 1975" was introduced by Representative Harley O. Staggers of West Virginia as H.R. 2049.

General Concept and Approach

The proposal would establish a three-part national health insurance program including (1) a plan requiring employers to provide specified private health insurance for their employees and their families, (2) a voluntary plan for individuals, and (3) a federally financed plan providing health insurance for aged, low-income, and medically indigent persons administered through Federal contracts with insurance carriers. The benefits of these plans would be the same.

State governments would have major responsibility for administering the health insurance program and regulating providers of health services and insurance carriers, in accordance with Federal regulations. The State would also regulate and assist health maintenance organizations (HMO's) which would provide comprehensive health care services to enrolled population.

COVERAGE FOR EMPLOYEES

The plan requiring employers to provide specified health insurance coverage for their employees would include a broad range of services, generally subject to cost sharing by the individual. Additional catastrophic benefits would become payable when expenses exceed a specified amount. Coverage would be purchased from private insurance carriers, with the premium cost shared by employers and employees. Federal subsidies to employers and employees would be available under certain circumstances.

Coverage

The coverage requirement would apply to all employers subject to the social security tax. Where two or more members of the family are employed (or an individual has more than one employer) coverage would be provided by the employer paying the highest wages.

The participation of employees would be voluntary. Employed persons eligible for an employer plan are not eligible for the federally contracted plan even though they meet the requirements of the Federal plan (except for the aged, all of whom would be under Federal coverage).

Coverage for employees whose job is involuntarily terminated would be continued for 60 days, but would cease when the employee became eligible for unemployment insurance. Workers receiving unemployment insurance would receive coverage through the Federal-State unemployment insurance system.

In addition, coverage would be continued without regard to the cause of termination of employment (including coverage for a deceased employee's family) for 60 days or longer, with the length of coverage period and the arrangements for payment determined by the State health commissions (SHC) (established in each State, as described later).

Self-Employed and Other Persons

Coverage under the proposal would be available on a voluntary basis at reasonable group rates for all self-employed and other persons who are not eligible for federally contracted coverage. Each State health commission would make arrangements for coverage for the residents of the State, in accordance with Federal regulations.

Benefit Structure

The required benefits of the program would be phased-in in two stages with the initial benefits effective 3 years after enactment of the bill and the permanent ones (referred to as comprehensive health care benefits) 6 years after enactment. The phasing of covered benefits is shown in table 1 and the benefit provision in table 2. The comprehensive health care benefits include the regular benefits and catastrophic expense benefits, which becomes effective under conditions explained later.

Approved plans may include additional benefits (or eliminate or reduce the cost sharing). These are not subject to the general requirements or subsidies of the program.

Any policies offering protection supplementary to that in approved plans must meet State standards designed to assure that they are not promoted in a misleading manner and that they provide a reasonable ratio of benefits paid to premiums collected (i.e., retention ratio).

The comprehensive health care benefits are generally subject to cost-sharing provisions requiring the patient to pay a flat dollar copayment or a percentage of the charges. The amount of the flat copayments would be increased (if the Consumer Price Index (CPI) for a year rises by 3 percent or more over the previous year) at the same rate as the rise in the CPI.

TABLE 1.--STAGGERS BILL: Effective date of benefits

Group	Type of benefits and effective date 1/		
	2 years	3 years	6 years
General population: Employees----------	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.
Self-employed and others--------	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.
Persons receiving unemployment insurance---------	Basic health services.	Basic health services. Catastrophic expenses.	Comprehensive health care.
Federally contracted insurance: Aged----------	Basic health services and Medicare Part A. 2/	Basic health services and Medicare Part A. 2/ Catastrophic expenses.	Comprehensive health care.
Low-income---------	Basic health services.	Basic health services. Catastrophic expenses.	Comprehensive health care.
Medically indigent-	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.

1/ The effective data refer to the full fiscal years beginning after the date of enactment.

2/ Medicare Part B would continue to be available on a voluntary basis as under present law.

TABLE 2.--STAGGERS BILL: Comprehensive health care benefits

Type of service	Regular benefits			Catastrophic expense benefit
	Benefit (in benefit period)	Cost sharing	Other information	
Institutional services				
Hospital inpatient	60 days	$5 per day	Special provision for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on days.
Skilled nursing facility	30 days	$2.50 per day		No cost sharing.
Nursing home	60 days	$2.50 per day		No cost sharing.
Personal services				
Physicians' services:				
In home, office, and ambulatory center	50 visits per year	$3 per visit	Special provisions for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on visits.
In hospital and other institution	No limit	$2 per visit	Copayment applies only to attending physician.	No cost sharing.
Diagnostic services	No limit	20 percent	No cost sharing for enrollees in HMO's.	No cost sharing.
Health examinations	By regulation	None		
Immunizations	No limit	None		
Family planning services	No limit	None		
Well-baby care:				
Under age 1	8 visits per year	None		
Age 1 to 2	4 visits per year	None		
Age 2 to 5	2 visits per year	None		
Home health services	100 visits per year	$2 per visit		No cost sharing.
Dental services (for children):				
Examination and cleaning	1 visit per year	None	For children up to age 7; once child is covered, benefits continue to age 12.	No cost sharing.
Other services	Routine dental care, by regulation.	20 percent		No cost sharing.
Vision services (for children):				
Examination	1 visit per year	None	For children up to age 15; includes services of physician or optometrist.	
Eyeglasses	1 set per year	20 percent		
Other services and supplies				
Prescription drugs	Drugs necessary for specified conditions requiring expensive drug therapy, or especially important to the public health; by regulation.	$1 per prescription.	List of drugs to be shown by generic names.	No cost sharing.
Prosthetic devices	By regulation	20 percent	Includes hearing aids.	No cost sharing.
Medical equipment	By regulation	20 percent		No cost sharing.
Ambulance services	No limit	20 percent	Only when medically necessary.	No cost sharing.

The bill provides for preventive health benefits, to be established by regulation, and indicates that consideration to be given to providing physicial examinations as follows:

Age 5-24.....	One examination every 5 years
Age 35-39.....	One examination every 2 years
Age 40 and over.....	One examination each year

The regulations would also establish the services and diagnostic tests included in preventive health benefits and these could be varied for different age, sex, and other population groups.

Physicians' services are defined to include services of allied health personnel under the supervision of a physician.

Mental Illness, Alcoholism, and Drug Abuse

Special provisions would apply to care for mental illness, alcoholism, and drug abuse and dependence. Inpatient hospital care for these conditions is covered only if the condition is in an acute phase. Inpatient care is limited to 45 days (instead of the usual 60) but this special limitation would not apply to a patient enrolled in an HMO.

Outpatient care for these conditions is also covered, subject to the usual 50-visit limit and copayment of $3 per day. (The copayment may be waived, by regulation, for treatment of drug abuse or dependency.) Day care and similar part-time services are specifically covered, for a maximum of 120 visits per year. The bill states that the regulations governing the mental illness services should be designed to encourage the use of outpatient programs.

The benefits include skilled nursing facility services which are provided in lieu of hospital care to patients who require active treatment. (There is no requirement for a previous hospital stay.) Benefits also include nursing-home care providing a less intensive level of care (referred to as health-related custodial care) for patients with an incurable disease who are bedridden, require certain nursing procedures, or meet other conditions.

Catastrophic Expense Benefits

The catastrophic expense benefits would liberalize the conditions applicable to the regular benefits. They would eliminate the cost sharing for all benefits and remove the limits on the number of inpatient hospital days (except for care of mental illness, alcoholism, and drug abuse) and for all physicians' and other ambulatory services.

The catastrophic benefits would become effective and be payable when specified noncovered medical expenses reach a certain total (the expense limit), which varies according to family income and age. The expenses that would be counted in determining this expense limit are (1) premiums paid for an approved health insurance policy, (2) expenses for cost sharing, and (3) expenses resulting from the limitation on the number of inpatient hospital days (except for mental illness, alcoholism, and drug abuse), skilled nursing facility days, physicians' visits, and outpatient mental illness, alcoholism, and drug abuse services. Expenses incurred in the last 3 months of a year would be included in the next year's expense limit.

The family income classes (which are based on family size and income) used in determining eligibility for catastrophic benefits are the same as those used in determining eligibility for federally contracted coverage (see page 103). A separate set of limits is applicable to families with heads under age 65, and those age 65 and over. For the lowest income class, the expense limit is zero and the catastrophic benefits are always in effect. The expense limit for the highest income class is not specified, but is calculated as 15 percent of income. The limits are shown as follows:

Family income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$300	$150
3	600	300
4	1,000	500
5	15 percent of income	

The expense limits would be increased (if the CPI rises by at least 3 percent in a year) at the same rate as the increase in the CPI.

The initial benefits, referred to as basic health services, are the same benefits required as basic health services required of federally assisted health maintenance organizations (HMO's). These benefits include physicians' services, hospital inpatient and outpatient care, diagnostic laboratory and diagnostic and therapeutic X-ray series, mental health services (45 outpatient visits and 21 hospital days), home health services, and preventive care (including dental care and eye examinations for children). The precise nature of these benefits and any limitations and cost sharing are not given further in the bill and would be established by regulations. The catastrophic expense benefits, when applicable to these initial benefits, would remove limitations and cost sharing made applicable to them.

Administration

The employer would purchase private health insurance for his employees from an insurance carrier qualified under the program. Also a health insurance plan must meet certain requirements to be eligible for the 10-percent subsidy for enrollees of an HMO, as described later.

Financing

The employer is required to pay at least 75 percent of the premium cost, and the employee the balance. Employers would receive subsidy payments from the Federal Government if their share of the premiums exceeds 4 percent of the average wages paid to employees. The subsidy would be equal to the amount of the excess, for a maximum of 10 employees.

If an employed person was also eligible for the federally contracted plan and his share of the premium contribution was larger than under the Federal plan, he would receive a subsidy from the Federal Government equal to the difference.

The premium for coverage for self-employed and other persons would be paid by the policyholder. Coverage for persons receiving unemployment insurance would be financed by the Federal Government.

10-Percent Subsidy

Covered employees, self-employed, and other persons would receive a Federal subsidy, if the family is registered with an approved HMO, of 10 percent of the group premium rate for covered benefits. The subsidy payment would be made to the HMO (or the carrier for the HMO).

COVERAGE OF AGED, LOW INCOME, AND MEDICALLY INDIGENT

The Federal Government would provide health insurance coverage for aged, low-income, and medically indigent individuals and families through contracts with insurance carriers. The permanent benefits would be the same as under the required employer plans, although the interim benefits would be phased in differently. The plan would be financed through premium contributions from the medically indigent and from Federal general revenues.

Coverage

Aged persons (65 and over) would be eligible for Federal coverage without regard to income or employment status, and eligibility for low-income

and medically indigent individuals and families would be based on family income and size, as follows:

Income class	Family size and income			
	Single individual	Family of 2	Family of 3	Family of 4 or more
1...	$0-$2,500	$0-$3,500	$0-$5,000	$0-$6,500
2...	2,501- 3,500	3,501- 5,000	5,001- 6,500	6,501- 8,000
3...	3,501- 5,000	5,001- 6,500	6,501- 8,000	8,001- 9,500
4...	5,001- 6,500	6,501- 8,000	8,001- 9,500	9,501-11,000

Note: Families are defined as parents and dependent children under age 19.

The families in class 1 are defined as the low-income group and those in classes 2, 3, and 4 as the medically indigent. The determination of income would be based on the adjusted gross income shown on the income tax return but specified kinds of income could be included or excluded, as determined by regulation, if they are considered as readily available for living expenses (or not so). Also income could be determined on a more current basis if necessary to prevent hardship.

The dollar amounts shown in the table would be increased (if the CPI in a year rises by 3 percent or more) at the same rate as the CPI.

Benefit Structure

The federally contracted insurance would provide the same permanent benefits subject to the same conditions as for employed persons, and these would begin 6 years after enactment of the bill (tables 1 and 2). Catastrophic benefits would also be payable, according to income class and age. The table of expense limits for catastrophic benefits (which also would be recalculated at the same rate as the increase in CPI) is repeated below:

Family income class	Expense limit	
	Under age 65	Age 65 and over
1.....	0	0
2.....	$300	$150
3.....	600	300
4.....	1,000	500

The initial benefits for the three groups under federally contracted insurance would be phased in, as described in table 1. The aged, among the first groups entitled to benefits, would initially receive the basic health services and continue to be covered under the Medicare hospital insurance program (Part A) and eligible to enroll in its voluntary supplementary insurance program (Part B). Medicare benefits would be payable to the extent that the benefits are not included in the basic health services under the new program.

Financing

The aged and low-income groups would not pay any premium for the Federal coverage. The medically indigent would pay an annual premium, according to their income class, as shown below. The amount of this premium contribution would be raised (if the CPI in a year rises by 3 percent or more) at the same rate as the rise in the CPI.

	Individual	Family
Class 2.....	$50	$125
Class 3.....	100	250
Class 4.....	150	375

The additional costs of the program would be appropriated from Federal general revenues--including the cost of the federally contracted insurance, the 10-percent subsidy, the subsidy for small employers, and the cost of coverage for the unemployed (all described previously), the administrative costs of the program, and a 5-percent reserve account. These costs would be based on past experience and expected changes in the cost of services, the number of low-income and medically indigent persons, the utilization of health services, and the amount of contributions from the medically indigent.

Administration

The Department of Health, Education, and Welfare would contract with insurance carriers for health insurance for persons eligible for Federal coverage. The carrier must meet all special requirements established by regulation and could include carriers underwriting an HMO or an HMO operating on a capitation basis, acting as its own carrier.

The negotiation of the contracts would not necessarily be subject to competitive bidding and other standard Federal contract requirements, but information about the proposed contracts would be made available to all carriers. Contracts to provide coverage in an area could be made with more than one carrier. Also, a contract could require a carrier to subcontract with other carriers, or a contract could be made with a combination of carriers (which have established a joint arrangement or organization for this purpose). The SHC could be used as an agent in negotiating contracts.

Enrollment

The conditions for enrollment of eligible families under the plan would be prescribed by Federal regulations. Periodic open enrollment periods would be held (which would be concurrent for the various carriers and HMO's offering federally contracted plans in an area).

The premiums of the medically indigent would be payable to the carrier, but the State commission (SHC) could be used as a fiscal agent for this purpose. As prescribed by regulations, a grace period, for a maximum of 90 days, would apply in event of nonpayment of premiums before the insurance could be terminated. However, delinquency or default could not affect the coverage of persons age 65 and over.

ADMINISTRATION AND REGULATION OF THE PROGRAM

Major responsibility for supervision of the program would be placed on the States which would administer it in accordance with Federal standards and regulations.

Administration

The primary Federal responsibility for the program would be lodged in the Department of Health, Education, and Welfare. The Department would be responsible for the establishment of Federal regulations, standards for qualified providers and carriers, review of State compliance with the program, evaluation of the program, liaison with national accrediting and related organizations, and annual reports to the President.

When proposing new or modified regulations, the Department would be required to issue a statement of the anticipated impact of the regulation on (1) the availability of care, (2) health resources and facilities, including HMO's, (3) the cost and quality of care, and (4) the practice of health professionals. The statement would also have to indicate possible alternatives to the proposed regulation and the reasons for their rejection.

A national health services advisory council consisting of the Secretary of HEW, and 20 members appointed for 4-year terms, would include representatives of providers of services and of consumers (with the latter to constitute a majority). The council would advise the Department on policy, and this would include prior review and comment on proposed regulations. It would make an annual report to the Department and the the Congress. The Department would be required to report to Congress its views on the council's recommendations about administration (if not adopted), and on their legislative recommendations.

State Administration

State responsibility for the programs would be placed in an independent State health commission (SHC) within the executive branch of the State government. The SHC would be composed of three, five, or seven members (with a maximum of two, three, or four members, respectively, from the same political party) appointed by the Governor for staggered 6-year terms. Representatives of the health care professions could not constitute a majority of the members. Members would be full-time employees, could not hold a financial interest in a health care provider, and could be removed only for cause.

The SHC would be advised by a State advisory council which would include representatives of providers (including HMO's, other providers, professional organizations and societies, and medical schools) and of consumers, with the latter constituting a majority.

State Health Care Plan

The major provisions relating to State administration of the program would be presented in the State health care plan which would include the regulations for providers of service and insurance carriers, including the regulation of HMO's.

The State health care plan would be developed by the SHC, in consultation with the advisory council, after giving the general public an opportunity to present its views. The plan would need to be approved by the Federal Government and a State with an approved plan would be considered a "participating State." Disapproval would be subject to a hearing and to review by Federal courts.

If the State failed to obtain an approved plan within 3 years after the year of enactment of the bill (unless it is granted an extension) the Federal Government could intervene and administer the program in the State. It could also suspend approval of the plan or parts of the plan (or bring civil suit in Federal Court) if an approved plan is not properly administered, or is later modified, so that it is no longer in compliance with law. These provisions are subject to hearings and appeals in Federal Courts. Also, individuals could bring suit in State courts to compel State compliance with the Federal law and regulations.

Federal grants would be available to cover the entire costs of developing a State plan. For administration, the Federal contribution would be 90 percent of costs for the year before benefits begin, 85 percent for the first 2 years of the program, and 75 percent thereafter.

Relationship to Other Government Programs

Federal financing for the Medicaid program would eventually be limited to services not covered under the new program (but would remain in effect for various population groups and services during the phasing-in period). Federal regulations would establish a new minimum scope of services (in lieu of those required under present Federal law) and these would be designed to supplement the benefits under the proposal.

In general, Federal health care providers would be excluded except when they function as community institutions or agencies, as determined by the SHC. Also, the use of Federal funds to provide health services under other programs would not be permitted if these services are covered under the proposal.

Providers of Service

Standards for participation of providers in the program would be established by Federal and State regulations. The minimum Federal standards and related provisions indicated in the bill are as follows:

(1) Hospitals, skilled nursing facilities, and home health agencies (including facilities of HMO's) must meet the standards of the Medicare program. (See Appendix.) To the same extent as under Medicare, approval by State agencies or accreditation by certain national organizations would be accepted.

(2) Home health services must be furnished by an HMO or by an agency meeting special regulations of the DHEW.

(3) HMO's and institutions can not be restricted by the State from providing services through direct employment of medical and other practitioners or through prepaid group practice or other arrangements (including prepayment, fee-for-service, or other basis).

(4) The use and qualification of allied health professionals as assistants to physicians and dentists must meet Federal standards (and these Federal Standards cannot be further restricted by State law).

(5) Providers of service would be required to comply with additonal Federal and State standards to be established by regulations concerning the quality, scope, and comprehensiveness of services. The SHC would review the performance of providers in these matters.

(6) Providers of service would be required to disclose information to the public about their charge schedules, hours of operation, and any license, accreditation, or certification held by the provider.

The SHC could take corrective action against a provider of service who fails to meet the standards and fulfill his other obligations, including suspension of payments for covered benefits (subject to hearing and court review).

Providers are prohibited, under penalty of Federal law, from soliciting or taking kickbacks or bribes in connection with covered services, or making rebates of fees or charges for referral of patients.

Health Planning and Facilities

The SHC would take responsibility for implementation and coordination of health facility planning including (1) plans developed under the State health care plan; (2) State, regional, and local plans under the Federal comprehensive health planning laws; and (3) plans under other Federal or State programs.

Construction, modernization, expansion (or rental, in certain cases) of health care facilities or services by hospitals, nursing facilities, HMO's, or other organizations would not be permitted unless approved in advance by the SHC and authorized by a certificate of need.

On request of the DHEW, the SHC would review and recommend on applications of providers and other organizations for grants and contracts under the proposal and under various Federal laws.

Study of Capital Needs

The national health service advisory council, mentioned above, would make a special study of the capital needs of HMO's and other providers to determine methods of supplementing current sources of capital financing. It would give consideration to financing capital needs from health insurance premiums, a tax on these premiums or appropriated government funds, and study methods of encouraging continuing contributions from non-Federal sources. It would also consider methods of properly allocating capital financing among the States and areas, with emphasis on the role of the SHC in such allocation.

Reimbursement of Providers of Services

Payments to providers of service would be based on approved charges of providers, in accordance with Federal and State regulations. The Federal regulations would prescribe a uniform system of accounting and would indicate the methods used, and the elements considered, in determining the financial requirements of providers of service and HMO's.

In accordance with these Federal regulations, the SHC would prospectively approve charges for institutional providers based on a review of their budgets. Charges for kinds of physicians' services provided in an institution which are generally available to all inpatients (such as radiologists and pathologists services) would be included in the institutions' budget and not as separate physicians' charges. Payment would not be made for duplicate or excessive services or in connection with facilities for which the capital expenditures were not approved by the SHC. Providers dissatisfied with the SHC's decisions would be entitled to a hearing before it. The approved charge schedule would be applicable to all qualified private plans and to federally contracted coverage. The SHC would also review charges of all licensed noninstitutional providers.

In general, the insurance carrier would pay the covered charges, and the patient would pay the cost sharing, to the provider. However, where a carrier insures an HMO (which is not on a capitation basis) the carrier would pay the covered charge to the HMO and collect the cost sharing from the patient. A carrier insuring an HMO on a capitation basis would pay the capitation amount to the HMO.

Regulation of Insurers

The Federal law would permit various kinds of organizations to qualify as insurance carriers under the program including organizations which pay for (or provide) health care on a group basis by contract, agreement, membership, or subscription arrangements. It could also include an HMO offering coverage on a capitation basis, acting as its own carrier. A qualified carrier must be authorized to operate by each State where it offers coverage and, if requested by the State, must participate in a State coverage pool. (These pools may be established by States to meet their obligation to make coverage available to all their residents, as described earlier.)

A qualified carrier must meet the Federal requirement that it have a reasonable ratio of the amount of benefits paid to the amount of premiums collected (the retention ratio). In determining the ratio for a particular group plan, consideration would be given to (1) the carriers' average ratio for all its group plans combined (2) the size of the covered group, and (3) the nonprofit or profit status of the carrier. The initial determination of the reasonableness of the ratio would be based on projections

and the DHEW would periodically review the actual experience of the plan.

For nongroup (individual) policies the ratio would have to be the same as the ratio for the smallest groups.

Subsidized Insurance Plans

To qualify for the 10-percent Federal subsidy for families enrolled in an HMO, a health plan must meet the following additional requirements as well as all other Federal and State requirements:

(1) Provide coverage and benefits without regard to health status (preexisting, current, or future), economic status, race, sex, occupation, age, or any conditions indicated in regulations (classification of risks for premium rate purposes would be permitted in accordance with actuarial principles).

(2) Provide for coordination of duplicate coverage, as prescribed by Federal regulations.

Regulation of Premium Rates

The approval and regulation of health insurance carriers, in accordance with Federal and State regulations, would (except where indicated) be administered by the SHC. Federally contracted plans, however, would not be subject to State regulations.

The SHC would be responsible for regulating the premium rates of carriers for qualified group insurance plans but (except for an HMO acting as its own carrier) regulation could be delegated to the State insurance department or other agency.

In addition, the SHC would enforce the following disclosure requirements for qualified carriers and plans:

(1) An annual audit of the carrier would be conducted by a certified public accountant and the audit report made public.

(2) Carriers would be required to disclose to the public the provisions of a qualified policy relating to its (a) benefits and exclusions, (b) premium rates, (c) whether, and under what conditions, HMO coverage is available, and (d) the percentage of the premiums expected to be paid in benefits.

(3) Carriers must provide to the DHEW and to the SHC reports and information, as requested, and make its records available for inspection.

In addition, in the event a carrier is found to be financially insolvent (or impaired) under State law, the SHC must provide arrangements for payment, guarantee, assumption or reinsurance of claims, and other obligations under a fund established or regulated by the State.

Amendments to the law or new regulations, enacted or issued in a year, which would affect the obligations or rights of carriers, would not go into effect until the following contract year (except where an earlier date was mutually agreeable).

Disputes and Claims

The SHC would provide hearings and settle disputes between individuals, providers of service, HMO's, and insurance carriers in the following situations:

(1) claims by individuals against a provider or carrier (or vice versa), where the disputed amount is $100 or more;

(2) allegation by an individual of the failure of providers to meet their obligations, where the failure is part of a pattern of similar conduct;

(3) claims by a provider against a carrier or HMO for payment of charges for services (or for capitation charges); or

(4) disputes among HMO's and providers.

Evaluation of the Program

A national uniform statistical program would be established by the DHEW. Each SHC would function as a center for the collection and analysis of health statistics and information, and providers, carriers, and HMO's would be required to report statistical information. (Safeguards would be provided to protect the confidentiality of identifying information.)

As prescribed by Federal regulations, the SHC would evaluate the health-related and economic effectiveness of its own activities, and of HMO's and other providers. The evaluation would include a comparison of utilization of services of HMO's and other providers. The evaluation and other reports required by regulation would be filed with the Department.

At the Federal level, the Department would evaluate all aspects of the program and could conduct studies of alternative methods of furnishing and financing health care.

HEALTH MAINTENANCE ORGANIZATIONS

The bill provides for the development and regulation of a system of health maintenance organizations (HMO's). The provisions and regulations generally applicable to the program, including those relating to providers of service and to insurance carriers, apply generally to the HMO's. Only additional and specialized provisions concerning HMO's are described below.

Establishment of HMO's

The SHC would have responsibility for encouraging the establishment of a system of HMO's in the State. It would assist various organizations wishing to establish approved HMO's by providing information and advice, and assistance in applying for Federal grants.

The SHC would issue certificates of approval to qualified organizations to operate as HMO's in geographic service areas. The HMO's, when applying for approval, would indicate their service area. The service areas need not coincide with existing political boundaries and could extend across State lines, and the SHC would assist in arranging with other States to monitor HMO's serving in more than one service area. Service areas of HMO's would be allowed to overlap.

Applications of organizations to qualify as an approved HMO would be evaluated according to the following criteria:

(1) The organization must have competent management and adequate finances, facilities, and personnel.

(2) The need for an HMO in the area must be justified.

(3) If an HMO is already established in the area, the need for an additional one must be justified, on the basis that it will be economically feasible and provide a choice of sources of health care to the population.

Approvals for HMO's would be issued after providing an opportunity for a hearing to take testimony from the applicant, other organizations proposing an HMO for the same area, and the public. The SHC (or another designated State agency) would incorporate the HMO under applicable State law.

Enrollment

The bill indicates that the HMO's should enroll persons who are broadly representative of the age, social, and income groups in the area.

Periodic open enrollment periods would be held, as determined by Federal and State regulation. Before the enrollment period, the HMO must disclose full information to the public about its operations and services. Generally, it must enroll all applicants living in its service area, not discriminate on grounds of race, age, occupation, or health condition, and make reasonable efforts to enroll persons assigned by the SHC. An applicant who is not accepted could obtain a hearing before the SHC.

For an organization with limited capacity, enrollment may be limited with the approval of the SHC on a first-applied basis, but only if other approved HMO's are available for persons who wish HMO coverage. Also, with the SHC's approval, a HMO could enroll persons living outside its area and other persons it is not required to enroll. The HMO would assist eligible enrollees to obtain federally contracted coverage.

Medical Services

The bill states that the services of the HMO would, to the extent possible, (1) emphasize health maintenance and health education, (2) assure continuity of care and appropriate referral, (3) provide maximum care on an outpatient basis, (4) make services readily available, and (5) furnish outpatient care in centers and offices accessible throughout the area.

To qualify as an HMO, the organization would be required to furnish basic health services, as described previously, and to the extent possible supplemental health services. The supplemental services are long-term care, vision care, dental services, mental health care, physical therapy and rehabilitative services, and prescription drugs (in all cases, these benefits are in addition to any included under basic services).

For persons covered under the insurance provisions of the program, HMO's would be required to assume responsibility for all benefits covered by the insurance. It must schedule a periodic health examination for each insured enrollee, and emergency and ambulance services must be made available at all times.

The HMO would also be required to provide health education services designed to encourage healthful living and proper use of services, especially for low-income and medically indigent enrollees, with special assistance given to persons with language or educational handicaps.

A continuing personal health record (including medical histories and other information) would be maintained for each enrollee and be made available to the HMO staff and other appropriate providers. These records would be transferred when a member transfers to another HMO. The health records (which could also be used for statistical purposes) could not be disclosed without the enrollee's permission, except when necessary for the administration of the program.

The HMO would be required to give emergency services to persons not enrolled with it and, if resources are available, could provide other services to nonenrollees.

Methods of Providing Services

The HMO could provide services directly through its own staff and facilities and through arrangements with other providers of services. Professional services may be provided by arrangements with medical groups or individual practice associations. A medical group is defined as an organization of individuals licensed in a State to practice medicine, dentistry, or other specified health professions who engage in the coordinated practice of their profession, share medical records and equipment, employ allied health professionals, arrange for their continuing education and meet other specified requirements. An individual practice association is an organization which has prearranged arrangements for compensation of its professional members and, to the extent possible, also coordinates and shares services and engages in activities similar to those of medical groups.

Quality of Services

The HMO must establish a quality assurance system providing for review by physicians and other health professionals (1) the process followed in the delivery of health services and (2) the quality of the results obtained through the health services provided. The SHC would approve the quality assurance system and conduct continuing surveillance of its performance.

The HMO would coordinate needs for health personnel, and would set qualifications and performance standards for personnel at least equal to the standards established by professional organizations. It would also conduct in-service training, encourage the use of paramedical personnel, and conduct other activities designed to meet its manpower needs and improve the quality of care.

Charges and Reimbursement

Charges of HMO's would be approved by the SHC, based on the financial requirements needed to fulfill its responsibilities, in accordance with the general principles of reimbursement described previously.

Initially, the HMO could charge its enrollees either an annual capitation amount for all covered services for the year, or a separate charge for each service rendered. However, capitation must be made available to persons wishing to enroll on this basis within 5 years after the HMO's incorporation. The basic capitation amount would be based on a "community rating system." This is defined as a system under which the capitation rate would be the same for all enrollees, varied only by family size and to reflect differences in the administrative costs of enrolling individuals, small groups and large groups (as determined by DHEW regulations). Different capitation rates would be allowed also for federally contracted insurance under the program and for certain contracts with specified Federal, State, and local government agencies.

HMO's would be responsible for payment for medically necessary services provided to its enrollees by out-of-area HMO's and emergency services furnished by other providers.

While the HMO must assume full financial risk on a prospective basis for the provision of health services for its members, it may insure itself against (1) the cost of basic health services of more than $5,000 in a year for one member, (2) costs applicable to members receiving services while outside its service areas, and (3) part of its losses for the year, resulting from a significant underestimation of its costs for that year.

HMO's would be required to protect themselves against the risk of insolvency, under a method approved by DHEW.

Representation and Grievances

The HMO must be organized in a way which assures its membership an important role in policy making. It must establish an advisory committee to represent its enrollees (and additional subcommittees or separate committees to represent groups of members with special interests) and provide other methods of permitting them to express their views on its policies and operations.

Also, the HMO would be required to establish procedures for handling grievances of enrollees or applicants for enrollment (and maintain records of the grievances for inspection by the SHC.

Disclosure Requirements

HMO's would be responsible for keeping records and reports on financial matters, utilization of services, and results of quality assurance programs. These records would be available for inspection by the SHC for verification.

In addition, the HMO would annually issue a report to the DHEW (which would be made public) on the (1) cost of its operations, (2) pattern of utilization of services, (3) availability and acceptability of its services, and (4) improvement in the health status of its members, if this is known.

Enforcement Powers

If the SHC determines that an HMO is not complying with laws or regulations, it could direct the organization to correct the situation, take other action such as placing the HMO in receivership, or amend or repeal its approval. These orders or actions would be subject to hearings and court review. Also, other interested parties such as other HMO's and providers could initiate an action to amend or revoke the approval of an HMO.

Federal Grants

The bill states the policy of the Federal Government to provide technical and other assistance in the development of HMO's and authorizes, to the extent needed, funds for financial assistance for their planning, development, and initial operation. It specifically provides for grants for new or expanded outpatient care centers for HMO's. (These grants would also be available to other nonprofit or governmental providers.)

In providing this financial assistance (which would be subject to the conditions and terms generally applicable to similar Federal programs) the Government would consider the resources already available in various geographical areas and attempt to provide an equitable distribution of facilities. A maximum of 15 percent of the funds could be granted in any one State. For the first 5 years of the program, priority would be given to HMOs operating on, converting to, or planning to convert to, a capitation basis and thereafter only to such organizations. Applications for financial assistance must be approved by the pertinent SHC and planning agencies.

LUJAN BILL

The "National Family Health Protection Act," was introduced by Representative Manuel Lujan, Jr. of New Mexico as H.R. 3672.

General Concept and Approach

Under the proposed program families would receive a health protection certificate from the Federal Government which would be used to obtain a private insurance policy providing specified benefits. The program would be financed by a surtax on Federal personal income tax and supervised by the Department of Health, Education, and Welfare (DHEW).

Coverage

All residents of the United States would be covered.

Benefits

The specified insurance would be issued for a 1-year period and would have to be guaranteed renewable. Some services would be subject to cost sharing. The major benefit provisions are as follows:

Type of service	Limit on benefits	Cost sharing
Institutional services:		
Hospital inpatient.....	No limit----------	First 120 days, none; 121-240 days, 20% of costs; over 240 days, 50% of costs. 1/
Extended care facility....		
Personal services:		
Physicians home and office visits.....	No limit----------	$50 annual deductible; maximum payment of $5 per visit.
Physician hospital visits.	No limit----------	----------
Home health services.....	No limit----------	----------
Laboratory and X-ray.....	No limit----------	----------
Other services and supplies:		
Medical equipment and supplies.....	No limit----------	----------
Ambulance services.....	No limit----------	----------
Maternity care.....	No limit----------	$100 annual deductible.

1/ However, after 365 days, cost sharing would be limited to 2 percent of family adjusted gross income in the year of illness.

Administration

The Department of Health, Education, and Welfare would be responsible for general administration of the program and use government, public, and private agencies to assist in operating the program.

Families would ordinarily apply for a health protection certificate on their Federal income tax return. (For this purpose, a family is defined as (1) an unmarried individual with no dependents or (2) two or more persons living together, related by blood or marriage, and at least one of whom is claimed as a personal exemption on the tax return.) Special applications could also be filed during the year in certain cir-

cumstances. The Department would issue certificates which families could use to purchase a specified health insurance policy from qualified private insurance carriers.

Qualified carriers would accept the certificates and issue the health insurance policies. To be qualified, a carrier would be required to be approved by the State, agree to accept the certificates as payment of premiums for policies, participate in assigned-risk pools, and make payments into the health protection reserve fund (described below).

The qualified carriers would redeem the certificates with the Department. They would receive the actuarial value of the certificates determined by the Department, as described below.

Under Department regulations, eligible families unable to obtain a qualified policy, because they constitute high medical risks, would be placed in a pool and assigned from the pool to qualified carriers.

Relationship to Other Government Programs

The bill repeals the Medicare and Medicaid programs. It also calls for a report from the Department on legislative changes needed in other Federal health care programs and for improvement of the proposed program.

Financing

The program would be financed by a 5-percent surcharge on adjusted income tax on the personal income tax return.

Each year, the Department would determine the estimated average amount of expenses under the qualified policies for the following year, that is, the estimated actuarial value of the policies. Once determined, this estimated amount could not be changed.

A health protection reserve fund would be established by the Federal Government and be used to make benefit payments under a policy when a carrier, because of insolvency or other reasons, is unable to do so. Qualified carriers would pay into the fund amounts needed to provide a satisfactory reserve.

Standards for Providers of Services

Providers of services would be required to meet the same standards as under the Medicare program.

Reimbursement of Providers of Services

Hospitals, extended care facilities, and home health agencies would be reimbursed on the basis of the reasonable cost of services, in a similar manner to the Medicare program.

Physicians' surgical services would be reimbursed on the basis of relative value scales determined by the Department, after consultation with the medical societies in each State. These payments could vary on a State basis.

Delivery and Resources

There are no provisions regarding these subjects.

CORMAN-KENNEDY BILL

"The Health Security Act" was introduced by Representative James C. Corman of California as H.R. 21 and Senator Edward M. Kennedy of Massachusetts as S. 3.

General Concept and Approach

The bill would establish a national health insurance program covering the entire population and providing a range of health services with no payment required of the patient. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. The program would be administered by the Department of Health, Education, and Welfare. The proposal includes provisions designed to reorganize the delivery of health services, improve health planning, and increase the supply of health care manpower and facilities.

Coverage of the Population

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. Alien residents employed by a foreign government or an international organization would be eligible for coverage under special agreements. Persons would be eligible for benefits without regard to whether they have contributed to the program.

Benefit Structure

The benefits of the program, which would be provided with no cost sharing required for the patient, are shown in table 1.

The health security board, upon finding that adequate funds and resources are available, could by regulation extend or remove the 120-day limit on days in a skilled nursing facility. This could be done for all participating nursing homes or only for those, owned or affiliated with a hospital, which have a consolidated budget with a hospital.

Physicians and outpatient services would include preventive care services including health examinations, immunizations, well-child care, and family planning services.

Medical appliances and equipment including eyeglasses and hearing aids would be covered if included on a list to be issued by regulation. In establishing the list, the board would seek to avoid a rate of expenditure for these items which exceeds 2 percent of total spending for all covered services.

TABLE 1.--CORMAN-KENNEDY BILL: Covered services under the proposal

Type of service	Limit on amount of services	Other information
Institutional services		
Hospital inpatient	No limit	Special limitation on mental illness (see text).
Skilled nursing facilities	120 days per spell of illness.	Days may be extended by regulation (see text).
Personal services		
Physicians' service	No limit	Special limitations on mental illness (see text). Includes preventive services.
Home health services	No limit	.....
Laboratory and X-ray	No limit	.....
Dental care	No limit	Initially for children under age 15; phased in for persons under 25 and eventually to entire population (see text).
Podiatrist services	No limit	Excludes routine foot care.
Vision services	No limit	Includes exams and eyeglasses.
Hearing services	No limit	Includes exams and hearing aids.
Other personal services: Physical therapy, psychological, nutrition, social work, health education, and related services	No limit	Covered only when furnished by an institution, HMO, or other agency under contract.
Other services and supplies		
Prescription durgs	Limited as indicated	Limited to drugs required for chronic conditions and other specified conditions, but no limit if provided by an HMO (see text).
Prosthetic devices	No limit	.....
Medical supplies and equipment	No limit	.....
Ambulance services	No limit	.....

Mental Health Services

Outpatient mental health services would be limited to 20 visits in a benefit period, but with no limit if provided by a health maintenance organization (HMO), hospital, community mental health center, or other mental health clinic furnishing comprehensive mental health services. In communities where psychiatric services are in short supply, regulations could require that these services be available only upon referral or under other specified conditions.

Inpatient hospital care in psychiatric or general hospitals would be limited to 45 days in a benefit period. Coverage is also provided for care in a mental health day care service for a maximum of 60 days during or following a benefit period if provided by a hospital (or an affiliated service), group practice organization, community mental health center, other comprehensive mental health center, or a mental health day care service organization.

Services for alcoholism and drug abuse would not be subject to the limitations applicable to mental health care. Services for these conditions would be available from all participating providers including free-standing alcohol and drug abuse centers.

Dental Care Services

The covered dental services would include preventive services, examinations, treatment, and rehabilitation, but exclude orthodontia. In the first year of the program, coverage would be limited to children under age 15 and each year thereafter would be extended to children 2 years older (e.g., in the second year to under age 17) up to age 25. By regulation, this extension of coverage by age group could be accelerated beyond that required by law. Within 7 years of the start of the program regulations must be established for extending coverage to the rest of the population, phased in by age or other types of groups. Encouragement must be given to the provision of dental care by HMO's, other approved comprehensive care organizations, primary care organizations, and comprehensive dental care organizations and by regulation the extension of coverage could be limited temporarily or permanently to services provided by these organizations.

Prescription Drugs

The types of prescription drugs covered on an outpatient basis would be limited to those drugs required for specified chronic diseases for which drug therapy usually imposes financial hardship and for other specified conditions requiring costly drug therapy. Regulations would establish a list of covered drugs available for treatment of these specified conditions. The physician or dentist, when prescribing the drug, would be

required to identify the condition for which the drug is being prescribed. Regulations could require that a physician or dentist could prescribe a drug for a specified condition only if he is a specialist qualified to diagnose and treat that condition.

These limitations on drugs would not apply to health maintenance organizations which could prescribe from a list of drugs, established by regulation, designed to provide a full range of needed drugs.

In establishing lists of prescription drugs, consideration would be given to (1) whether the drug is safe and effective and (2) whether it is available at reasonable cost. Drugs would always be listed by their generic names and, where appropriate, also by their trade names.

Experimental services which, because of cost or shortages, could not be provided on a nationwide basis would be excluded.

Administration

The program would be administered by the Department of Health, Education, and Welfare. A 5-member, full-time health security board, appointed by the President with the consent of the Senate, would serve under the Secretary of Health, Education, and Welfare. Board members would have 5-year overlapping terms and no more than three could belong to the same political party. The board would be responsible for general administration of the program including policy and regulations, control of expenditures, and standards and reimbursement for providers of services.

A national advisory council, appointed by the Secretary, would advise the health security board on general policy, regulations, and allocation of funds. The council would include the chairman of the health security board and 20 members including representatives of consumers (who would constitute a majority) and of providers of services. A commission on the quality of health care would be established in the Department to recommend to the Secretary and the health security board standards relating to the quality of care.

The program would be administered through the regional offices of the Department and local health service areas. Regional and local advisory councils, comparable to the national advisory council, would advise the regional and local offices. Individuals or providers with grievances would be entitled to hearings, appeals, and judicial review in Federal courts.

Relationship to Other Programs

The Medicare program for the aged would be abolished. Federal grants for the cost of covered services for the Medicaid, vocational rehabilitation, and maternal and child health programs would be terminated. Services under the CHAMPUS program (for military dependents and retirees) would be limited to noncovered services.

The DHEW would establish by regulation a new minimum scope of benefits required under an approved State Medicaid program. These new minimum benefits would be designed to supplement the benefits of the health security program and would include additional skilled nursing home care, dental care, and prescription drugs.

Federal providers of services including the Department of Defense, Veterans Administration, and the Department of Health, Education, and Welfare facilities for merchant seamen, Indians and Alaskan natives would not be eligible providers under the national plan. HEW health centers would be eligible providers. Agencies providing school health services would also be eligible for reimbursement. Medical services under a Federal or State's workmen's compensation law are not affected by the proposal. The bill requires a study of methods of coordinating HEW and veterans programs with the proposed plan.

Malpractice

In legal cases against a provider for damages for injury caused by negligence or other fault in furnishing services under the program, damages would not be awarded for the cost of remedial services for which the injured person was eligible under this program.

Financing

The program would be financed by (a) a 1.0-percent tax on wages of employees, (b) a 3.5-percent tax on employers' payrolls, (c) a 2.5-percent tax on self-employment earnings, (d) a 2.5-percent tax on unearned income, and (e) contributions from Federal general revenues equal to the total receipts from taxes.

The total income of an individual from wages, self-employment, and unearned income subject to taxes would be limited to an amount equal to 150 percent of the earnings base under the social security program. (The base under social security for 1976 is $15,300 annually and the equivalent base under the health security proposal would be approximately $22,950. By law, the base under social security is automatically revised each year in accordance with changes in wage levels.) The total payroll of employers would be subject to the employment tax.

The tax on unearned income would be applicable to all types of income, not subject to one of the special taxes of the proposal, included in adjusted gross income for income tax purposes. For persons age 60 and over, the first $5,000 of unearned income would be exempt.

The employment tax would apply to employment covered under social security and to employment by Federal, State, and local governments, but State and local governments would not pay the employer's share of the tax. Service in the U.S. Armed Forces would not be taxed.

The bill indicates its intention that the current obligation of employers to pay for health benefits for their employees should not be reduced because of enactment of the proposal. Employers whose per capita costs for health benefits at the start of the program exceed the cost of their payroll taxes under the proposal would be required to absorb the employees share of the payroll taxes up to the amount of their current obligations. If the employer's obligation, under any agreement in effect at the start of the program, is greater than the total combined employee-employer taxes and any supplementary health benefits provided, the employer must pay his employees the excess amount involved (at least for the duration of the agreement). By mutual agreement, this requirement could be met by providing other types of benefits of equivalent value.

The funds of the program would be held in a health security trust fund with three accounts: (1) a health service account to pay benefit costs, (2) an account for administrative costs, and (3) a health resources development fund. The present hospital and medical insurance trust funds of Medicare would be transferred to the new trust fund.

Under present law, all financial transactions of the Federal Government (including the social security and Medicare trust funds) are presented in the Federal unified budget. Under the bill, the health security trust fund would be separated from the budget and its operations reported in a separate statement. (The Federal general revenue contribution to the trust fund would be shown as an expenditure of the Federal budget).

Providers of Services

The standards for participation by providers of services would be similar to those of Medicare, but would also include others. (Medicare standards are shown in the Appendix). In addition, all providers must agree that (1) services would be furnished without discrimination on the basis of race, color, or national origin, (2) no charge would be made to the patient for covered services, and (3) required information and records would be supplied.

Institutional Providers

Standards for general hospitals are similar to those under Medicare, with two additional requirements. Hospitals cannot refuse to grant staff privileges on grounds other than professional qualifications, and they must have a pharmacy and a committee to supervise drug therapy.

In addition to meeting Medicare standards, nursing homes must be affiliated with a hospital or HMO whose medical staff assumes responsibility for professional services in the nursing home. They must meet the requirements of the Life Safety Code of the National Fire Protection Association.

The standards for home health care agencies are similar to those for Medicare.

Health Maintenance Organizations

Two types of health maintenance organizations (HMO's) could qualify to participate in the proposed program--group practice organizations and individual practice associations. A group practice organization is defined as a public or nonprofit organization which provides services to an enrolled population through group practice or other approved arrangements. The organization must be responsible for provision of all covered services, except mental health and dental services.

Physicians services must be furnished by an organized medical group associated with the organization. The members of the group, whose principal professional activity must be furnishing services for the group, must also (1) pool their income from practice and distribute it according to a prearranged salary, percentage, or similar plan and (2) jointly use medical records, medical equipment, and services of the paramedical and administrative staffs.

All other services (except institutional services) must be furnished through its own staff and facilities or by contract with another provider, in which case the organization must take full responsibility for the availability and quality of services given by the contracting provider. Institutional services could be furnished by arrangements with another provider.

The group practice organization must assume financial responsibility for all its services without reinsurance except that reinsurance may be obtained for (1) the annual cost of services for any one enrollee which exceeds an amount--not less than $5,000--to be specified by regulation, (2) the cost of institutional services provided by arrangements with other providers, and (3) the cost of services obtained by contract with other providers. In addition, the organization must meet the following requirements: Premiums or other charges for noncovered services must

be reasonable. Within its capacity, it must accept all persons in the area who wish to enroll. The organization must provide preventative services, assure continuity of care, and make services readily available to enrollees. It must have a committee which would establish medical standards and review utilization and quality of services. The organization would also need to meet the general requirements of the program concerning continuing education of professional personnel, and other requirements (to be established) concerning quality of care. It must employ paramedical personnel to the extent possible.

An individual practice association would be an organization sponsored by a local medical society which provides services to an enrolled population in an area contiguous with the medical society area. The association, which would be organized on a nonprofit basis, would be required to furnish the same covered services as the group practice organization and could also provide other types of covered and noncovered services. The association must permit all qualified physicians to participate, including those not members of the medical society. It would take responsibility for compensating its professionals and other providers furnishing services on its behalf on a basis it prefers, including fee-for-service.

The association would need to meet requirements similar to those for group practice organizations regarding open enrollment for the public, reasonableness of charges for noncovered services, and requirements for continuing education and quality of care. The requirement that services be provided through group practice or similar arrangements is not applicable.

Other Health Service Organizations

Under an agreement with the health security board indicating the conditions and standards for participation, other health service organizations could qualify as providers as follows:

(1) Public or nonprofit organizations which furnish all covered services. At its option, the organization may provide institutional, dental and mental health services by arrangement with other providers.

(2) Public or nonprofit centers which furnish primary health care services and make arrangements with other providers to furnish all covered services.

(3) Public or nonprofit mental health centers and mental health day care centers.

(4) Public health agencies furnishing preventive or diagnostic services.

(5) Public agencies furnishing health services in primary or secondary schools.

(6) Free-standing alcoholism, drug abuse, family planning, and rehabilitation centers.

(7) Medical or dental group practices and clinics, dental foundations, and other organizations furnishing ambulatory care.

An independent laboratory or radiology service or provider of drugs, medical appliances, or ambulance services, would need to meet requirements of State law and additional ones established by regulation.

Professional Practitioners

Physicians, dentists, optometrists, and podiatrists licensed in a State before the start of the program would be eligible to participate, but would need to meet requirements for continuing education established by regulations. National standards for professionals would be established by regulation for those licensed after the program began. A State-licensed practitioner who met the national standards would be considered qualified in any other State. Services of professional practitioners provided in a nonparticipating hospital would not be covered.

Surgery and Specialized Procedures

Major surgery and other specialized services designated in regulations would be covered only when furnished on referral by a physician in general or family practice and only when performed by a specialist.

Also, for specified types of surgery, also indicated in regulations, prior consultation and approval by other qualified specialists would be required. For these specified types of surgery, regulations could also require that a pathology report and clinical abstract or discharge report be submitted. If the surgery is not approved under these provisions, the cost of the hospital and other services incident to the surgery would also not be covered. The provisions described above would not apply in case of emergency services (except for the requirement for a clinical report).

For these requirements, a physician would be considered a specialist if he is (1) board certified or board eligible, (2) authorized on the basis that he has experience in the speciality, meets specified standards established by regulation and, where appropriate, is recommended by a participating hospital.

Continuing Professional Education

By regulation, requirements for continuing education would be established for physicians, dentists, optometrists, and podiatrists. These requirements would take into consideration standards for continuing education which have been issued or approved by professional organizations. Reports on compliance with these requirements would need to be filed. Practitioners who fail to comply could be suspended or terminated from participation in the program, or from performing specified types of services under the program.

Utilization Review

The requirements for utilization review in hospitals and skilled nursing homes include all those of Medicare. In addition, the hospital utilization committee would report its findings, on request, to the Health, Education, and Welfare regional office. For skilled nursing homes, utilization review would be conducted by a State or local public health agency under contract with the Department, or by the HEW regional office.

Independent physicians and dentists in general practice must maintain records and make reports, as required by regulations, for purposes of medical audit.

Quality of Health Care

The bill establishes in the DHEW a commission on the quality of health care consisting of 11 members appointed by the Secretary for 5-year terms, including 7 members representing providers of service or organizations involved in setting health care standards and 4 members representing consumers. The commission would develop methods of assessing the quality of care and methods of using these assessments to improve quality. It would recommend to the Department and the health security board standards for quality of care.

The health security board, with the advice of the commission, would be responsible for improving the quality of care. Its objective would be to require the highest practicable quality of care attainable in all areas of the United States. If the health security board refused to adopt a standard recommended by the commission, the final decision would be made by the Secretary of the DHEW.

The health security board could contract with Professional Standards Review Organizations (PSRO) established under the 1972 amendments to the Medicare and Medicaid laws, to monitor the quality of institutional and other services within the PSRO area. The PSRO would report on the compliance of providers with the quality standards of the program. The PSRO's activities would be designed to supplement (not duplicate) similar activities conducted by State agencies and the health security board.

Newly Constructed Facilities

Hospitals, skilled nursing homes, and ambulatory care facilities which wish to construct new facilities or substantially enlarge existing facilities would be required to obtain (1) a certificate of need or other approval of the State health planning agency or (2) approval of the health security board. Failure to obtain approval would result in exclusion of the provider from participation in the program.

Scope of Services

Except for individual professional practitioners, participating providers could be directed to add or discontinue covered services, provide services in a new location, arrange for transfer of patients and medical records, and establish coordination or linkages with other providers.

Also, the participation of a provider in the program could be terminated if (1) the provider's services are not necessary to the program and their continuation is unreasonably costly or (2) the provider's services are being furnished inefficiently and at unreasonable cost, efforts at correction have not been successful and the services can be furnished more efficiently by other providers. These actions could be taken only on the recommendation of, or after consultation with, the State health planning agency and is subject to hearings, appeals, and judicial review.

Reimbursement of Providers of Service

National Health Budget

Each year, a national health budget for the coming year would be established. The budget would be based on the cost of the program in the current year adjusted for estimated changes in the Consumer Price Index, population, and the number and capacity of providers. Consideration would also be given to the extent to which costs are being controlled by improvements in delivery. However, the budget could not exceed the estimated total receipts for that year from taxes and general revenues.

The budget could be modified during the fiscal year if later estimates of tax receipts or expenditures differed significantly from the original estimates or if an epidemic or similar event required higher expenditures. A needed increase in a budget would be promptly reported to Congress.

Allocation of Funds

Funds would be allocated to each region on a per capita basis for institutions, physicians' services, dental services, drugs, appliances, and other professional and miscellaneous services. The amount for each category would be based on that spent during the past year modified for

estimated changes in various factors (as described previously). The regional funds would be further allocated on a similar per capita basis to the health service areas. The bill provides authorization to eliminate unwarranted differences in average costs of health services among the regions by curtailing increases in funds to high expenditure regions and increasing the availability of services in low expenditure regions.

Hospital and Nursing Homes

General hospitals would receive a predetermined annual budget under regulations establishing the costs and services to be recognized in the budget. A uniform accounting system would be required. The compensation of professional practitioners (such as pathologists and radiologists) associated with the hospital would be included in the budget.

A psychiatric hospital rendering primarily active treatment to patients would be paid on the same basis as a general hospital. Those also providing noncovered services (such as custodial care) would be paid a predetermined rate per patient-day for the covered services.

Payments to skilled nursing homes and home health agencies would be based on an annual budget as for general hospitals.

Health Maintenance Organizations

HMO's would receive a per capita amount for enrolled persons for ambulatory services they are required to provide, based on the per capita allocation for the various services in the local area.

If they also provide hospital or nursing home care in their own facilities, they would receive an annual budget amount for these services. If they arrange for hospital or skilled nursing home services through other providers, they would be reimbursed on the basis of an amount per patient-day for services used by their enrollees. The organization would be entitled to 75 percent of any savings resulting from its lower utilization of institutional services (whether furnished by the organization or through other providers) compared to that of a similar population group.

As an alternative, the payment for hospital and nursing home care would be based on a reasonable per capita payment per enrollee, in which case the organization or foundation would retain any savings resulting from lower than estimated use of these services.

Other Health Service Organizations

Other organizations such as health centers and State or local health agencies could be paid by any agreed method, other than fee-for-service.

Independent pathology laboratories or radiology services could elect fee-for-service, approved budget, or any other agreed basis. Methods of payment for other types of providers would be specified in regulations.

Payment to Professional Practitioners

The major methods of payment available to physicians, dentists, and other professionals would be fee-for-service, capitation, and salary.

Fee-for-service would be generally available to all. The amount of fees would be determined by fee schedules or relative value scales, prescribed by regulation after consultation with representatives of the professions. The administration of fees could be delegated to a medical or professional society (or an agency selected by the society).

Capitation would be available only to independent physicians and dentists in general or family practice. An annual amount would be paid for each person enrolled to receive all services from the practitioner. These professionals could receive fee-for-service payments for services to persons not enrolled with them on a capitation basis.

By agreement with the local or regional office, a practitioner could be paid a full-time salary, or he could receive a part-time salary as a supplement to other methods of compensation. By agreement, specialists could also be paid per session or per case.

From the predetermined fund for physicians, dentists, and other professional services for an area (based on the per capita allocation for these types of services in the area), funds would be allocated to professionals selecting salary, capitation, and fee-for-service. If, during the year, total payments for fee-for-service were greater than allocated, the amount of fees would be reduced proportionately.

The bill authorizes experimentation with other methods of reimbursement if they would not increase costs.

Delivery and Resources

Financial assistance would be provided, before the start of the program, for the purpose of alleviating shortages and maldistribution of facilities and manpower and improving the organization and delivery of health services. The appropriations for this purpose would amount to $200 million and $400 million, respectively, for the 2 years before the program begins. After the program starts, all expenditures for improvement in delivery and resources would come from the health resources development fund (except as noted below). This fund would receive, in the first year, 2 percent of the total income of the program and this allocation would be increased by 1 percent (at 2-year intervals) until it reached its ultimate rate of 5 percent.

Health Planning

The bill directs the DHEW and the health security board to undertake planning to improve the supply and distribution of manpower and facilities and the organization of health services. This planning would be guided by the planning activities under Title 15 of the Public Health Service Act, as amended by the National Health Resources and Development Act of 1974, including the national health priorities established by the DHEW and the plans developed by State and local planning agencies.

Grants and Loans

The provisions of the bill authorizing financial assistance for resource development state that priority would be given to improving services on an ambulatory basis provided as part of a system of comprehensive care. Financial aid would be available to the following types of organizations (the first three of which are described in further detail in the section on providers of service):

(1) Group practice organizations.

(2) Public or nonprofit centers which furnish all covered services (except institutional, dental, and mental health services).

(3) Public or nonprofit centers which furnish primary health care services and make arrangements with other providers to furnish all other covered services.

(4) Nonprofit organizations furnishing comprehensive dental services which meet requirements to be set by regulation.

The organizations described above could receive financial assistance as follows:

(1) Grants of up to 90 percent of the costs of planning and developing a new organization, and up to 80 percent of these costs for expanding an existing organization.

(2) Loans for construction of new facilities of up to 90 percent of costs for a new organization and up to 80 percent for an existing organization.

(3) By contract with the health security board, payment of the operating deficit of a newly established or enlarged organization for as long as 5 years, if the organization is making progress toward self support.

In addition, grants could be made to these four types of organizations for the costs of (1) improving utilization review activities, (2) improving financial and statistical systems, and (3) installing diagnostic and therapeutic equipment.

Grants would be available to these four types of organizations as well as all other organizations which provide covered services for the purpose of improving coordination and linkages between (and among) institutional and noninstitutional providers.

Manpower Training

The health security board would establish priorities for education, training, and recruitment of health manpower. Funds for this training would be provided by contracts with educational or other organizations, and stipends could also be paid directly to students. Funds are authorized for training or retraining, as follows:

(1) Training of medical students for general or family practice and for specialties in critical shortage.

(2) Training for professional and nonprofessional occupations, if other Federal financial assistance is not available or adequate.

(3) Training for development of new kinds of health personnel, especially those useful in providing comprehensive health services. The new occupations could include teaching of personal health care, liaison with health care organizations, and consumer representatives. Under this provision, additional grants could be made to organizations to study the usefulness of the new occupations.

Special remedial education and additional stipends could be provided for members of disadvantaged groups who are training for health occupations.

The board would also have general authority to train and recruit professionals who agree to practice in urban or rural areas of acute shortage, or in the four types of organizations eligible for financial assistance described above, and to pay these practitioners a stipend to supplement their professional earnings for up to 5 years (and for an additional period where appropriate).

Other Federal Assistance

Financial assistance under the program could not be used to replace funds available under other Federal programs and the Executive Branch of the Government is directed to use these funds to further the objectives of the national program. The health security program could loan 90 percent of the non-Federal share (the funds which the sponsor of a project ordinarily contributes) required under another government program. Where a loan has been obtained under another Federal program, the health security program could pay the interest on the loan that exceeds 3 percent.

Grants for Programs of Personal Care Services

The bill provides grants to develop community programs of personal care services designed to maintain persons in their own homes who might otherwise require institutional care. These grants could be made to public or nonprofit hospitals, group practice organizations, or other qualified organizations. The amount of the grant would be sufficient to pay all or part of the cost of a personal care program for a maximum period of 4 years and could be varied to meet a decreasing share of the cost over the period of the grant. The grantee could be required to develop other (non-Federal) sources of financing deemed appropriate considering the economic resources of the community.

Each program would be designed to serve a substantial population in a specified area as designed in the grant. To be qualified, an organization must provide all the health services covered under the health security program (except institutional services which could be furnished by arrangements with other providers). As designated in the grant, each program would provide personal care services appropriate to its particular area which could include homemaker and home help services, home maintenance, laundry services, meals-on-wheels and other nutrition services, and assistance with transportation and shopping.

Each grant contract would prescribe the criteria for eligibility under the personal care program and these criteria could differ among the various programs. An eligibility committee would be established for each program. The composition of each committee, which would need to be approved by the health security board, must include at least one physician, one professional nurse, one professional social worker, and three representatives of the users of services. The committee would determine eligibility of persons for services, review the continuing use of services, and terminate eligibility for persons no longer qualified.

Each local organization would be required to evaluate the benefits of its program to persons served by the program and the fiscal impact of the program. The health security board would evaluate the various programs and report these findings in its annual report to Congress. By the third year after enactment of the health security bill, the health security board would report to Congress its overall evaluation of the personel care service program, together with recommendations concerning (1) methods of expanding the program to all areas of the Nation, (2) methods of continued financial support for the personal care program, and (3) the role of the health security program in providing long-term institutional care (and the possibilities of substituting personel care services as an alternative).

In the 2 years before the start of the health security program, the personal care services program would be financed from the Federal general revenues appropriated for improvement in health delivery and resources, discussed above. After the start of the program, it would be financed from the health resources development fund.

MATSUNAGA BILL

"The Health Security Act" was introduced by Representative Spark M. Matsunaga of Hawaii as H.R. 3674. It is similar to H.R. 21 introduced by Representative James C. Corman of California and S. 3 introduced by Edward M. Kennedy of Massachusetts.

The major differences between this bill and the Corman-Kennedy bill are that it--

(1) covers 52 physicians visits for mental health services outside of an organized setting,

(2) covers psychologist services for mental conditions if the psychologist is certified or licensed and the services are of a kind which the State authorizes to be furnished by these practitioners, and

(3) recognizes a psychologist as a "physician" for various purposes of the program.

DINGELL BILL

The "National Health Insurance Act" was introduced by Representative John D. Dingell of Michigan as H.R. 94.

General Concept and Approach

This proposal would establish a national health insurance program covering almost all residents of the United States. Standard benefits are broad and they would be financed through payroll taxes and Federal-State general revenues. The program would be administered by the Federal Government but would be decentralized with major administrative responsibilities placed at the State and local level. The bill contains provisions designed to improve the supply, quality, and distribution of health manpower and facilities.

Coverage of the Population

Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered and all persons eligible for social security benefits would be protected. Funds appropriated for various Federal-State health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

Benefit Structure

The proposal permits broad medical benefits but, in implementing the program, benefits would be made available in accordance with a State plan. The standard benefits available without limit, except as indicated, are as follows:

Institutional Services

General hospital inpatient care: 60 days.
Psychiatric and tuberculosis hospital care: 30 days; length of stay can be extended by regulation if funding and facilities are adequate.
Hospital outpatient care.

Personal Services

Physicians' services.
Dentists' services.
Physical checkups: periodic medical and dental examinations.
Home health services.
Podiatrists' services.
Optometrists' services and eyeglasses.
Laboratory and X-rays.
Physical therapy and related services.

Other Services and Supplies

Medical appliances.
Prescription drugs: types of drugs which are unusually expensive.

If the national health insurance board in consultation with the national advisory medical policy council (both created by this bill) finds that available resources are inadequate to provide dental, home health, or certain other specified services, it may limit these services for a period. In the case of dental services, priority would be given to children.

Administration

The program would be administered at three levels of government--Federal, State, and local--with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a health care plan. The State plans would be submitted to the national health insurance board and, when approved, the board would contract with the State for the administration of the program within that State.

Federal Level

A national health insurance board with five members would be established in the Department of Health, Education, and Welfare. Three members would be appointed by the President to serve with the Surgeon General and the Commissioner of Social Security. The board would establish the regulations and standards for the program, supervise the States and allocate funds. If the board finds that a State is not complying with the provisions of its plan, the board can administer the program in that State.

A national advisory medical policy council would be established, consisting of the chairman of the national board and 16 members appointed by the Secretary of Health, Education, and Welfare. At least eight

members would serve as consumer representatives and at least six as representatives of providers of medical services. The advisory council would advise the board on matters of general policy and administration, establishment of professional standards, and other matters.

State and Local Levels

The administrative agency in each State would, if possible, be the same agency that administers its public health or maternal and child health programs. State plans would:

(1) provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers;

(2) establish local health-service areas and provide methods for selecting their advisory committees;

(3) provide for surveys of resources and needs of the State;

(4) give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers, and carry out related administrative duties.

Relationship to Other Government Programs

Initially, aged persons could receive those benefits of the program not provided under Medicare. The Department of Health, Education, and Welfare would be required to study the relationship between the national health insurance plan and the Medicare program and devise methods of incorporating Medicare into the national plan. Funds appropriated for Medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who do not make regular contributions required by the program.

Financing

A personal health service account would be established to hold the funds of the national program. The account would receive an amount equal to 3 percent of total earnings. (The definition of earnings would be the same as under the social security law.) In addition, for the specific purpose of financing the cost of dental, home health, and certain other services, the account would receive an additional amount

equal to one-half of 1 percent in the first year of the program. This additional amount would increase to an ultimate rate of 1 percent in the third year. Further, in the first year of the program, an additional 1 percent of earnings would be appropriated as a reserve and the bill authorizes any additional funds required to meet expenditures. While the bill does not specify the source of any of these funds, the apparent intent is that they be obtained from a payroll tax on employers and employees covered under social security.

Standards for Providers of Services

Standards of participation for providers of services under the program would include the following:

Hospitals and Institutions

Hospitals or institutions qualified under State standards could participate in the program. If a State has not established standards, the national board would establish them for the State.

Professional Practitioners

Physicians, dentists, and podiatrists legally authorized to practice in a State would qualify. Specialists would be required to meet standards established by regulation.

Nurses

Professional nurses registered in the State would qualify. Practical nurses qualified under State standards or standards established by regulation could provide home health services.

Reimbursement of Providers of Services

The national board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home health, and auxiliary) on the basis of population, availability of health resources and the costs of services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits are provided in all States and to improve the adequacy of services where they are below the national average.

The State agencies would contract with providers of care for services under the program and determine rates of payments. The payments could be administered by the State agency or the local health-service area. Nonprofit health-service insurance plans could be used as agents or intermediaries.

Hospitals and Other Institutions

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. In calculating costs, the payment for room and board would be based on the least expensive multiple-bed accommodations. A maximum rate for hospitalization could be established (after consultation with representatives of provider organizations) and it could vary according to locality and class of service.

Professional Practitioners

Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of registered patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods and, in addition, payment on a per session or per case basis.

Rates of payment would be geared to local conditions. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Further, reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue postgraduate studies, maintain high-quality service, allow for adequate vacation, and practice in areas where their services are needed.

Home Health and Other Services

Methods of payment for home health and other services would be determined by the State agency administering the program.

Delivery and Resources

The national health insurance board, after consultation with the national advisory council and other Federal agencies, is authorized to make grants-in-aid for training and education to students and educational institutions. To finance this program, $10 million would be available for the first year of the program, $15 million for the second, and for each following year an amount equal to one-half of 1 percent of benefit expenditures in the previous year.

YOUNG BILL

The "Comprehensive National Health Care Act of 1975" was introduced by Representative Andrew Young of Georgia as H.R. 10888.

General Concept and Approach

The bill would establish a national health insurance program administered by the Social Security Administration and financed by special taxes on wages, self-employment, unearned income, and by Federal excise taxes. It would provide a scope of health benefits with no cost sharing by the patient. The proposal introduces new methods of reimbursement of providers of service and additional standards and regulations for providers.

Coverage of the Population

All residents of the United States would be eligible under the program. Residents of foreign nations, with which the United States has a treaty providing for reciprocal payments for health care benefits, would be eligible while in the United States.

Benefit Structure

The benefits under the plan include hospital, skilled nursing facilities, physicians, home health, and diagnostic services, and such additional benefits as certain prescription drugs and preventive care services, as shown in table 1.

The program would not exclude benefits for pre-existing medical conditions, require any waiting period before benefits become payable, or impose any maximum limit on the total dollar amount of benefits payable on an annual, lifetime, or other time basis. Benefits would not be subject to any cost sharing by the patient.

Mental Illness

Under special limitations applying to mental illness, inpatient care in a psychiatric hospital is limited to 45 days in a year. Partial hospitalization (such as day or night care) is specifically covered, limited to 90 days per year.

The annual maximum amount of benefits payable for outpatient mental illness services would be initially calculated by estimating the total charge for 50 visits to a private practitioner for the treatment of mental illness. (For example, 50 visits at say $30 a visit, or $1,500.)

TABLE 1.--YOUNG BILL: Covered services under the proposal

Type of service	Limit on benefits	Other Information
Institutional services		
Hospital inpatient	No limit	Special limitations for mental illness.
Skilled nursing facilities	180 days per year	Available after a hospital stay of 3 days or more.
Personal services		
Physicians' services	No limit	Includes home, office, and hospital visits. Special limitations for mental illness.
Home health services	180 visits per year	----------
Laboratory and X-ray	No limit	----------
Outpatient physical therapy services	No limit	----------
Podiatrist services	No limit	----------
Preventive services		
Physical examinations	By regulation	----------
Family planning services	By regulation	Includes services and supplies.
Prenatal and maternity care	By regulation	----------
Dental services	No limit	Routine services including examinations, fillings, extractions and replacements; excludes orthodontia.
Vision services	By regulation	Includes eye examinations and eyeglasses.
Hearing services	By regulation	Includes examinations and hearing aids.
Other services and supplies		
Prescription drugs	Limited as indicated	Limited to list of drugs of types used in treatment of chronic illnesses and other specified conditions.
Blood and blood products	No limit	----------
Prosthetic devices	No limit	----------
Medical equipment and supplies	No limit	----------
Ambulance services	By regulation	Only when medically necessary.

However, the amount determined by this calculation represents the maximum amount of benefits payable annually for care in an approved comprehensive community care center. For care by a private practitioner or in other settings, the annual benefits payable would be two-thirds that maximum amount. (In the illustration above, $1,000.)

In either case, no limit is set on the actual number of visits in any setting. (The reference in the bill to 50 visits is given only to provide a basis for calculating the annual maximum dollar amount of benefits that would be payable.)

Outpatient Drugs

Coverage of outpatient drugs would be limited to a list of drug categories, shown in the bill, representing mainly drugs used in the treatment of certain chronic illness but also including oral contraceptives. A formulary committee, described later, would compile the formulary--the list of covered drug entities and dosage and strength information appropriate to them. In compiling the formulary, the committee would be guided by information concerning the (1) clinical equivalence of various drug entities and (2) the relative usefulness of various drug entities in treatment of illness.

Financing

The program would be financed by special taxes on income and by excise taxes. The tax on income would be similar to the taxes imposed on earnings under the Medicare program, but also including unearned income and certain assistance payments. The total amount of income subject to the special taxes would be unlimited. The income subject to the special tax would be taxable at specified rates as indicated in table 2.

Tax Credits for Individuals and Employers

Persons paying the special taxes on their wages, self-employment, and unearned income would be entitled to a tax credit against their personal income taxes of one-half of their contributions, with a maximum credit of $250 for an individual return and $500 for a joint return. Employers would also receive a tax credit of one-half of their contributions, with a maximum credit of $750 for each employee for whom contributions were made.

Tax on Wages

The wages subject to tax would include all employment now compulsory covered under Medicare and, in addition, wages of employees of the Federal Government, State and local governments, and nonprofit organizations. Pay of members of the Armed Forces would be excluded.

TABLE 2.--YOUNG BILL: Special taxes, by type of income and tax rate

Type of income	Recipient of income		Other payor		Total tax rate
	Payor	Tax rate	Payor	Tax rate	
Wages	Employee	2%	Employer	6%	8%
Self-employment income	Self-employed person	5%	--	--	5%
Unearned income	Recipient	5%	--	--	5%
AFDC	Recipient	2%	State Government	6%	8%
SSI	Recipient	2%	Federal Government	6%	8%

The bill indicates its intention that the current obligation of employers to pay for health benefits for their employees should not be reduced because of enactment of the proposal. Employers whose per capita costs for health benefits at the start of the program exceed the cost of their payroll taxes under the proposal would be required to absorb the employees share of the payroll taxes up to the amount of their current obligations. If the employer's obligation, under any agreement in effect at the start of the program, is greater than the total combined employee-employer taxes and any supplementary health benefits provided, the employer must pay his employees the excess amount involved (at least for the duration of the agreement). By mutual agreement, this requirement could be met by providing other types of benefits of equivalent value.

Unearned Income

Unearned income subject to the special tax would include all income included in adjusted gross income under the Federal income tax law (with rents, dividends, interest, and royalties specifically mentioned). In addition, any payment received as an annuity, pension, retirement or disability benefit--including veterans compensation, OASDI payments, railroad retirement annuities and pensions, and unemployment insurance payments would be included. Persons eligible under the Medicare program and persons under the age of 18 would be exempt from the unearned income tax.

AFDC and SSI

As indicated in table 2, cash payments under the AFDC and SSI programs would not be treated as other unearned income. They would be subject to tax at rates for the recipient and the government similar to the employee-employer tax rates.

Withholding of Assistance and Unearned Income

The State agency administering the AFDC program, and the Federal agency (SSA) administering the SSI program would withhold the recipients' share of the special health insurance tax from the cash payment due their recipients. Also, the DHEW could make arrangements with other public and private agencies (for example, agencies paying pensions, unemployment insurance, etc.) to deduct and forward recipients' taxes due on their payments.

Excise Taxes

The present Federal excise taxes on alcohol, tobacco, and firearms would be diverted to, and used to finance, the proposed program.

Trust Fund

A newly established national health care trust fund would receive the taxes and other revenues. The fund would be managed by a board of trustees in a manner similar to the trust funds of the Medicare program.

ADMINISTRATION AND REGULATION OF THE PROGRAM

Administration

The bill states that in creating the contributory social security benefit and health insurance programs, the Government has assumed the obligation to honor these earned rights, assure the long range fiscal integrity of the programs financed by income dedicated to the programs, and provide for nonpolitical, objective, and skilled program administration.

Under present law, the SSA is a component agency of the Department of Health, Education, and Welfare (DHEW) with the duties of administering certain programs delegated to it by the Department. The bill establishes an independent SSA headed by a 3-man board (with one member designated chairman) appointed by the President with the advice and consent of the Senate. The board members, only two of which may belong to any one political party, would serve 5-year terms. The board would appoint an executive director and a general counsel. (The present position of the Commissioner of SSA would be eliminated.)

The independent SSA would administer the old-age, survivor and disability insurance (OASDI) program, including the black lung program, SSI, and the proposed new national health insurance program. All functions of the DHEW with regard to these programs would be transferred to the SSA, including the requirement to study and recommend methods of improving economic security.

Advisory Council

A national health insurance advisory council would be established. Its 19 members, serving 4-year terms, would include persons outstanding in the field of medical care, including representatives of organizations of medical professional personnel and of the general public.

Area health care service boards would be established in areas contiguous with the health service areas established under the National Health Planning and Resources Development Act of 1974. The boards would have 15 members appointed by the SSA on the recommendation of the elected bodies of counties and cities in the area. Five of the members would represent providers and 10 would represent consumers. The boards would participate in the administration of the program, including the establishment of methods and rates of reimbursement and standards for participation of providers, as described later.

Drug Formulary Committee

As mentioned earlier, a national health insurance formulary committee would compile and publish the health insurance drug formulary (the list of drugs covered by the program). The committee would be composed of the Commissioner of Food and Drugs and four other persons appointed by the SSA. These four members, who cannot be Federal employees or have any interest in the composition of the formulary, would elect one of themselves as chairman.

The committee would have full access to information on drug products from all Federal agencies and could request information from drug manufacturers, suppliers, and other persons.

A manufacturer of a drug product not included in the formulary could petition the committee for its inclusion, and if denied, would be entitled to a hearing before the committee. Similar procedures would apply to drugs, previously included in the formulary, which the committee has decided to remove.

Separate Budget

Under present law, all financial transactions of the Federal Government are presented in the Federal unified budget. The bill would separate the trust funds of the programs of the independent SSA from the general fund of the Treasury (commonly known as the administrative budget).

Freedom of Choice

The bill states an intent that the administration of the program not interfere with the freedom of physicians and patients to choose where and how they will give or receive medical care. It states that the government would not be permitted to make medical judgments, but only physicians could do so.

Relationship to Other Government Programs

The Medicare program for the aged and disabled would be abolished. The Federal Medicaid assistance law would be repealed. Other Federal medical programs including those of the Veterans Administration, Indian Health Service, and the CHAMPUS program for military dependents would continue, as would Federal and State workmen's compensation programs.

Reimbursement of Providers of Service

Institutional providers of service--hospitals, SNF's, home health agencies, neighborhood health centers, community mental health centers, and HMO's--would be reimbursed on a prospective reimbursement basis.

Prospective reimbursement methods would be established by the SSA, after consultation with the area health care service boards. Various methods of reimbursement could be made available to all providers and additional methods in specific regions or States. The SSA must give 60 days notice concerning a proposed method to the House Ways and Means Committee and the Senate Finance Committee, before final issuance of the method.

Providers would select a reimbursement method for the coming year from the approved national, regional, or Statewide methods available to them. Their selection must be approved by SSA. Once approved, the prospectively determined amount of payment under the agreed method may not be changed for the year, except in case of natural catastrophe or unexpected changes in demand or patient case mix not under control of the provider, as indicated in regulations. A provider could appeal an SSA decision regarding exceptions to the Provider Reimbursement Review Board (established by P.L. 92-603 and incorporated into the proposed program).

The SSA could withdraw a reimbursement method if an insufficient number of providers elect it or the method does not achieve improved results.

Criteria for Prospective Payment Methods

Prospective payment methods offered by the SSA would need to meet the following standards and criteria:

(1) The method would be designed to (a) provide financial incentives for efficiency of operations equal to the potential difference between the prospective rate and actual costs, (b) assure providers that their total income will equal their financial requirements, (c)

include the participation of the provider in implementing the method, (d) assure high quality services to patients, and (e) maintain independent management, discretion, and responsibility on the part of the provider.

(2) The rate of payment would recognize the provider's total cost of operation, including costs attributable to approved capital expenditures, costs of approved working capital, and costs due to bad debts.

(3) The payment rate would provide a reasonable return on invested equity capital, based on rates of return on investments of comparable risk, for for-profit providers. Nonprofit providers would also be paid a rate of return on capital to recognize the risks assumed under prospective payment methods.

Providers could also receive a quality management payment of 50 percent of the difference between its rate of increase in costs in a year and the increase in the "class average rate." The class average rate represents the average increase in costs for the 3 previous years for all providers in the same class group (according to a method of grouping of similar providers to be developed by SSA). A provider receiving a quality management payment would be required to pay at least two-thirds of the payment to their employees and medical staff, under a plan approved by its governing board.

If the provider's increase in costs exceed the class average rate, 50 percent of the difference would be added to its increase in costs in the next year before computing any possible entitlement to a quality management payment for that year.

Physicians and Other Health Professionals

Payments to physicians and other health professionals would be based on a fee schedule proposed by the area health care service board for its area. The schedule must be approved by the SSA. The SSA would be required to give approval if it determined that the average fee for the year would be no higher than that for 1973, after adjustment to reflect economic changes over the years as indicated by an appropriate economic index.

An approved schedule would ordinarily be in effect for a 1-year period, but the board could propose a new schedule at any time. The new proposal would be evaluated by SSA on the same basis as described above. If no schedule is proposed, or the proposed schedule is not approved, one would be established by the SSA based on a schedule for a similar area.

Physicians and other professionals could elect as participating or nonparticipating practitioners. Those participating would agree to accept the fee schedule amount as full payment for their services and be paid the scheduled amount for a service (under the health care reimbursement system described later). Further, they could submit a single consolidated bill for all covered services for a period and receive a single check rather than billing separately for each patient, as under present Medicare.

Nonparticipating physicians could charge the patient more than the established fee. The established fee would be paid to the patient and the physicians would need to collect their entire fee from the patients. They could not use the consolidated billing procedures. A fee schedule in effect in an area and the names of participating practitioners would be made available to the public.

Outpatient Drugs

Outpatient drugs would be paid according to a reasonable allowance, based on the cost of the drug to the pharmacy or other final dispenser (referred to as the acquisition cost) and a dispensing fee. The determination of acquisition costs would recognize differences in prices among regions and among various classes of dispensers. Where the prices vary significantly, an average price by region and class of dispenser could be set by SSA. Differences in price among named drugs would be recognized, but any named drug whose price exceeds 125 percent of the average price of the same drug would not be covered under the program.

Participating pharmacies and other dispensers would file with SSA the amount of their dispensing fee for the first year of the program, without limit on the amount. These filed fees would become the basis for reimbursement, except that no fee could exceed the 90th percentile of the distribution of the fees filed in the locality. For later years, the dispensing fee allowance would be increased by SSA on the basis of an appropriate economic index data. No dispensing fee would be paid to institutional providers or to physicians who dispense drugs (even to physicians who qualify as a "participating pharmacy" as described later).

Special provisions would apply to insulin products for which the reimbursement amount could be determined by SSA.

Other Medical Services and Supplies

The charges for other kinds of medical services, supplies, and equipment could not exceed the lowest charge levels at which they are widely and consistently available in the locality.

Reimbursement System

Persons covered by the program would be issued a health card, to identify them as enrolled, and a health card account would be established for each enrollee. These accounts would serve as the vehicle for payments from intermediaries, carriers, and other sources of reimbursement to participating providers of service (including all institutional providers, participating pharmacies, and physicians and other professionals who have elected to participate as described earlier). The health card account would pay the providers the established rate for their service. The SSA would be responsible for the operation of the health card system.

Administration of Payments Through Intermediaries and Carriers

Intermediaries and carriers would be used to administer payment of benefits in a manner similar to the present Medicare program. As under Medicare's hospital insurance program, institutional providers could elect to receive payment through a public or private organization which is under contract with SSA, called an intermediary, or may deal directly with SSA. (Most hospitals have elected Blue Cross plans as intermediaries.)

Under Medicare's supplementary medical insurance program, payments to physicians and others are administered through carriers, under contract with SSA, operating in assigned geographical areas. The proposal would continue these provisions but would require that (unlike Medicare) the contracts between SSA and carriers be subject to the competitive bidding procedures generally applicable to contracts under Federal law (Section 3709 of the Revised Statutes). Also, to be qualified, a carrier must have written at least 1 percent of the dollar value of health insurance in the United States in 1973, and must demonstrate that it is capable of efficient and effective claims operation.

Various types of organizations, including voluntary associations, corporations, and partnerships could qualify as carriers. The organization could be one which pays for or provides health services under group insurance policies, hospital or medical service agreements, or membership or subscription contracts. The SSA would establish and publish a list of all qualified carriers in the United States.

The proposal would permit an employer with at least 1,000 employees to select any qualified carrier under contract with SSA, in lieu of the assigned carrier in the area. All contracts with carriers would be terminated within 10 years of the start of the program. Afterward, the SSA would directly administer payment of benefits.

Participation and Regulation of Providers of Service

In general, the proposal incorporates the requirement and standards for participation of providers of service of the Medicare program (these standards are shown in the Appendix) including the applicable amendments

to Medicare under P.L. 92-603. The SSA would consult with State agencies and the area health care service boards in administering these functions.

As under Medicare, State health departments under contract with SSA would be responsible for determining compliance with the conditions for participation for institutional providers of service.

Additional Standards

Reflecting the additional benefits of the proposal, provision is made for expanded participation of optometrists and dentists who must be legally authorized to practice in their State. Chiropractors services are excluded from the new national health insurance program.

The additional standards also require that hearing aids only would be covered when authorized by a prescription written by a physician. Kidney dialysis and transplants are covered only if furnished in a facility meeting requirements established by regulation.

Services of a physician or other practitioner performed in a nonparticipating hospital would not be covered services under the program.

Participating Pharmacies

Drugs would be covered only when dispensed by participating pharmacies. They would be required to be licensed under State law, submit bills as prescribed by regulation, accept payment as described above, and comply with other provisions of the proposal. By regulations, a physician could be considered a qualified participating pharmacy in areas where no other pharmacists are available and when dispensing drugs in an emergency.

Physicians' Extenders

The bill also provides for participation of physicians' extenders--including physicians assistants, nursing practitioners, and similar personnel--who meet the following standards:

(1) They must perform services under the supervision and control of a physician, or act as his agent, and these services must be related to the supervising physician's type of practice.

(2) They must complete a training program, or pass a certification examination of an appropriate organization, or meet certain proficiency requirements--in all cases as approved under regulations.

(3) The charges for their services must be included in the bills of the supervising physician or employing organization.

(4) The performance of their services must be legal under State law.

Utilization Review

The proposal incorporates the provisions of P.L. 92-603 establishing the Professional Standards Review Organization (PSRO) to review the necessity and quality of inpatient services under Medicare and Medicaid, and extends these provisions to all inpatient and outpatient services covered under the proposed program. It also includes the P.L. 92-603 requirements for pre-admission review for skilled nursing care and home health services, as well as the general Medicare requirements for certification of the necessity of services and utilization review by the staff of institutional providers.

Surgery and Specialized Procedures

Major surgery and other specialized services designed in regulations would be covered only when furnished on referral by a physician in general or family practice and only when performed by a specialist.

Also, for specified types of surgery, also indicated in regulations, prior consultation and approval by another qualified specialist would be required. For these specified types of surgery, regulations could also require that a pathology report and clinical abstract or discharge report be submitted to the carrier with the claim for payment. If the surgery is not approved under these provisions, the cost of the hospital and other services incident to the surgery would also not be covered. The provisions described above would not apply in case of emergency services.

For these requirements, a physician would be considered a specialist if he is (1) board certified or board eligible, (2) authorized by SSA on the basis that he has experience in the speciality, meets specified SSA standards and, where appropriate, is recommended by a participating hospital, or (3) authorized by SSA because there is a shortage of these specialists in an area.

Control of Services, Facilities, and Capital Expenditures

The prospective payment method for institutional providers would not include payment for existing or proposed services or facilities of providers unless approved by the State and area planning agencies. The SSA could overrule the action of the State planning agency if it determined the agency's decision was arbitrary or capricious (or the agency took no action on a provider's proposal for more than 60 days, or did not afford the provider an opportunity for a hearing).

Further, no additional substantial capital expenditures may be made by providers unless approved in writing by the State and area planning agencies. Facilities obtained under lease arrangements would be subject to the same provisions. (The definition of substantial capital expenditure is the same as under P.L. 92-603.) The planning agencies determinations would be subject to review by the SSA whose decision would be final (and not subject to administrative or judicial review).

Health Resources Development

Funds from the national health care trust fund would be allocated to help finance the costs of the provisions of title 16 of the Public Health Service Act. These provisions, which were recently amended under the National Health Planning and Resources Development Act of 1974, give financial assistance in the form of grants, loans, and loan guarantees for construction of specified types of health facilities in accordance with area health planning. The allocation from the trust fund would be an amount equal to 2 percent of receipts during the first year of the program, 1-1/2 percent in the second year, 1-1/4 percent in the third year, and 1 percent in each year thereafter.

KETCHUM-LAGOMARSINO BILL

The "National Voluntary Medical and Hospital Services Act of 1975" was introduced by Representatives William R. Ketchum and Robert J. Lagomarsino, both of California, as H.R. 3252.

General Concept and Approach

The proposal would create a national health insurance program available on a voluntary basis to all U.S. residents. It would be financed by enrollee premiums and Federal general revenues and administered by the Federal Government. The proposal includes new methods of prospective reimbursement for providers of service.

Coverage

All U.S. residents could voluntarily enroll themselves and their families in the plan. In addition, employers who pay all or part of the premium required under the proposal could enroll their employees and the employees' families. Welfare agencies which pay all or part of the premium could enroll their public assistance recipients.

Benefits

Benefits would be payable with no cost sharing by the patient and no limitations of the amount of services. The covered services would be as follows:

Institutional services, including general and special hospitals, clinics, convalescent hospitals, nursing homes, and alcohol and drug toxification treatment centers.

Inhospital reconstructive oral surgery, performed by a D.D.S.

Physicians' services, including psychiatric care.

Diagnostic services, including laboratory and X-ray.

Podiatric surgery.

Two years after the start of the program, the agency administering the program would recommend to the Congress that specified additional services be covered if it believed such coverage was advisable and feasible.

Administration

The program would be administered by a new independent Federal agency called the national voluntary medical and hospital insurance agency, headed by a director nominated by the President and confirmed by the Senate. The director would appoint six assistant directors including at least three medical doctors. Each year, the agency would submit to the President and the Congress an annual report including an annual budget, a report on operations, and a financial statement of receipts and expenditures audited by the General Accounting Office.

Providers would submit all claims for payment on a standard form designed for computer processing. These claims would be audited for completeness and accuracy of information. Providers would receive a consolidated payment for all claims they submitted during a month. A record of a provider's claims during a month, and any individual claims raising doubt about the necessity for the service, would be submitted for review of utilization, as described below.

As a condition of enrollment or participation, enrollees and providers must agree to submit all claims for damages, resulting from alleged negligence or malpractice, for settlement under the arbitration procedures established by the program. Under these procedures, claims would be submitted to a board of arbitration consisting of physicians and attorneys nominated by the complainant and defendant and by the local medical and bar associations. If the board awarded damages, the agency would pay the damages to the complainant and recover this amount from the defendant. Decisions of the arbitration board could be appealed to the courts.

Relationship to Other Government Programs

The bill would terminate Federal funding under the Medicare, Medicaid, and CHAMPUS programs for services covered under the new program. Before the new program begins, beneficiaries of these three programs would be notified and supplied with information and applications for the new program. Direct medical service programs including the VA, Armed Forces, and Indian health programs would continue in operation, as would Federal and State workmen's compensation programs. Benefits payable under other government programs and private insurance plans would take precedence over those of the proposed program.

Financing

Enrollees would pay a premium of $15 monthly for each adult and $7.50 for each child under age 18 in the family. However, if family income were less than $833 monthly (about $10,000 per year), the premium would be reduced to a rate of 1.8 percent of family income for adults

and 0.9 percent for children (but not less than $3 monthly for adults and $1.50 for children). For example, a family with income of $400 monthly would pay a monthly premium of $7.20 for adults and $3.60 for children.

Each year, the Federal Government would pay from general revenues an amount equal to the premium income received. In addition, it would contribute $5 billion before the start of the program to establish a reserve. After the program has been in effect for at least 3 years, the agency may recommend to the Congress that premiums be increased if it found the financing of the program was not adequate.

The bill provides estimates of expected enrollment and costs. It indicates that expected enrollment during the first 3 years of the program would be about 100 million. The average premium would be about $9, and total premium income some $11 billion, to be matched by Federal general revenues. Maximum enrollment in later years is estimated at about 200 million and premium income and general revenues about $22 billion each. Those costs would be offset by savings from the elimination of Medicare and Medicaid of $18 billion in Federal spending and $23 billion in combined Federal and State expenditures.

Present Federal tax law would be changed so that premiums paid by subscribers could no longer be taken as a medical expense deduction under the personal income tax. Employers premium contributions would continue to be deductible as a business expense. Also, the tax law would be changed so that the value of the employer contributions would be counted as taxable income to the employee.

A new trust fund would be established to handle all funds of the program and these funds would be allocated as follows:

67 percent for hospital benefits
30 percent for medical and laboratory benefits
3 percent for administrative costs

If administrative cost exceed the amount allocated, Congress would appropriate the additional amount needed.

Standards for Participation of Providers

Providers of service must be approved by the agency to qualify as participating providers. Hospitals must submit with their application for approval evidence of certification and licensure and statements of ownership and financial conditions. Physicians licensed in their State would be approved as participating providers. Independent laboratories must submit evidence of professional competence and would be approved for specified tests and services.

Control of Utilization

The agency would be responsible for the review and final determination of the medical validity and the necessity and legality of covered services. For this purpose, the agency could make agreements with State or local medical societies or established Professional Standards Review Organizations (PSRO) to (1) advise the agency in making these determinations or (2) conduct the review of utilization on behalf of the agency and inform the agency of its findings.

In either case, the medical society (or PSRO) would be responsible for recommending that disciplinary action be taken against a provider and the nature of this action. In this case, the agency could order a temporary or permanent reduction in the regular scheduled payment to the provider. A medical or laboratory provider could be temporarily or permanently excluded from the program. If an enrollee was found abusing the program the agency could, after notice, reduce the benefits paid on behalf of the enrollee.

Action Against Providers

The agency could sue to recover payments to providers for service claimed but not provided, benefits not covered by the program, and services of a medical provider excluded from the plan.

For medical or laboratory providers, where a claim has been submitted with intent to defraud the plan, the agency could temporarily or permanently exclude the provider from participation.

Any order for exclusion of a provider (because of inappropriate utilization or of fraud, as described above) could be appealed to the agency and afterward to the courts.

To assist in detection, each enrollee would receive a listing of services claimed on his behalf each month. As a condition of his enrollment, the enrollee is required to notify the agency of listed service which he did not receive.

Reimbursement of Providers of Service

The agency would establish a schedule of per diem rates for each participating hospital based on the hospitals' financial statements and projected annual operating budget for the coming year, but also taking into account the operating costs of similar and comparable hospitals in the area.

Proposed capital expenditures must be approved in advance by the agency as a condition for the capital expenditure to be recognized in setting the reimbursement rates. Hospitals must agree to accept the agency's payment as payment in full and may not charge the patient any additional amount.

Physicians

Payment to physicians would be based on a schedule listing each diagnostic or treatment procedure associated with each recognized physical or mental illness and showing for each procedure the usual, customary and reasonable fee in that designated geographical area. The fee payable would be set as a percentage of this schedule fee. The agency would consult with the medical society in each area when establishing the original schedule and the percentage payable, and again each year when the fees would be revised. Physicians may charge the patient an additional fee, but must (1) post a sign in his office indicating that he may charge extra, (2) inform the patient in advance, and (3) disclose on the claim form filed with the agency the amount of the extra fee. However no additional fee may be charged if it would result in preventing access by the enrollee to necessary treatment.

Laboratories

Similarly, payment to laboratories would be established according to a percentage of the usual, customary and reasonable fees for each listed test or procedure. Laboratories must accept this payment as payment in full and may not charge the patient.

Enrollees receiving benefits from nonparticipating providers could file for reimbursement and would receive the percentage of the scheduled amount, or the provider's actual fee if smaller. Reimbursement on this basis would also be made for services outside the United States to enrollees temporarily living abroad who are away less than 1 year.

FULTON BILL

The "Comprehensive Health Care Insurance Act of 1975" was introduced by Representative Richard H. Fulton of Tennessee as H.R. 6222. It is endorsed by the American Medical Association.

General Concept and Approach

The proposal would establish a national program consisting of (1) an employee plan requiring employers to offer specified private health insurance to their employees, (2) a plan for continuation of coverage under employee plans for persons receiving unemployment insurance, and (3) a plan offering private insurance coverage for the nonemployed and self-employed, subsidized by Federal income tax credits or certificates of entitlement. All plans would provide the same benefits and would make supplemental coverage available to persons under the Medicare program.

INSURANCE FOR EMPLOYEES

The employee plan would require employers to offer employees a specified health benefits plan implemented through private insurance or similar arrangements. The premium cost would be shared by employers and employees. Special arrangements would be made to provide coverage for small employers at reasonable cost.

Coverage

All employers including Federal, State, and local governments would be required to offer coverage under an employee health plan to any employee who has been employed for more than 30 days and is:

(a) considered a full-time employee;

(b) not considered a full-time employee but is expected to work at least 20 hours a week for at least 26 weeks during the next year, or has in fact met these work requirements in the past year.

The plan must make coverage available to the employee and the employee's spouse and dependent unmarried children under age 19 (under age 23 if a full-time student). Persons under Medicare would be covered by the plan under special provisions, as described below.

An employee could enroll in an employer plan within 30 days of the start of employment or during open enrollment periods which would be held at least every 6 months. However, an employee could enroll at any time if coverage was needed to replace that previously provided by another family member (who is no longer employed).

At the option of the employee, coverage under the plan with regular employer contributions would be continued for 31 days after termination of employment. The employee could also obtain an additional 60 days of coverage by paying the entire premium. On this same basis, an employee covered under the special provisions for the unemployed could elect coverage under the employee plan for 60 days after this special coverage expired.

Benefits

Qualified insurance policies must be noncancellable and guaranteed renewable, and benefits could not be refused because of pre-existing conditions.

The services covered under a qualified policy are shown in table 1. General dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. (For example, in the second year of the program to age 7, in the third to age 8). Emergency dental services and certain kinds of oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations.

The physicians' and hospital outpatient benefits would include unlimited physical examinations, innoculations, well-baby care, and psychiatric care. The hospital inpatient benefit includes unlimited psychiatric care in a general or psychiatric hospital.

Persons under the Medicare program would receive an identical policy, but one which excludes all the benefits covered under the hospital and supplementary medical insurance parts of Medicare. This policy would not reimburse for the deductibles and coinsurance required under Medicare.

Table 1--FULTON BILL: Services covered under a qualified policy

Institutional services:	
Hospital inpatient services 1/	No limit
Skilled nursing facilities	100 days
Personal services:	
Physicians' services	No limit
Hospital outpatient services	No limit
Laboratory and X-ray	No limit
Home health services	No limit
Dental care	As specified 2/
Other services and supplies:	
Medical supplies and equipment	No limit
Ambulance service	When medically necessary
Blood and plasma	No limit 1/

1/ Excludes the first three pints of blood and plasma.
2/ General dental care for children; emergency dental care and oral surgery for all persons (see text).

Cost Sharing

All covered services would be subject to a 20-percent coinsurance payment by the patient. However, the coinsurance requirements would be waived entirely for families whose annual income is below the following specified levels.

Family size	Family income
One.....	$1,500
Two.....	3,000
Three.....	3,600
Four.....	4,200
Five or more.....	4,800

Further, the maximum annual amount of coinsurance for a family in a year would be limited to 10 percent of family income above these specified levels, but with an overall maximum on total coinsurance for the year of $1,500 for an individual and $2,000 for a family. Illustrations of the maximum amount of coinsurance payable under these provisions for a four-person family at selected income levels are shown below:

Annual family income	Maximum cost sharing
$5,000	$80
7,500	330
10,000	580
15,000	1,080
20,000	1,580
25,000	2,000

Thus, for a family with four with income of $5,000 annually, the remaining income after subtracting the $4,200 exempt amount is $800, and 10 percent of that amount is $80. The overall $2,000 limit on cost sharing for this four-person family would be reached at an income level of $24,200.

Administration

The employer would be required to inform his employees of their eligibility for a qualified plan and provide information about the plans' benefits and premium costs. He is forbidden by law to offer financial inducements for, or to require as a condition of employment, either acceptance or rejection of the plan.

The Federal Government could bring suit in court to compel an employer to comply with the law. Also, an employee could bring suit to obtain compliance and also to recover any medical care expenses of his family that would have been reimbursed under a qualified policy. An employer found by the court to have willfully failed to comply could be fined an amount equal to twice his cost of complying.

Financing

The employer would be required to pay at least 65 percent of the premium cost and the employees would pay any balance. The maximum premium rate charged by insurance carriers for employment groups with 1 to 100 employees could not exceed 125 percent of the average premium rate for employment groups larger than 100 in the State. Insurance carriers would be required to develop, by themselves or in combination with other carriers, plans for these small employers and could be required to participate in an assigned risk pool established by the State, as described later.

All employers covered under the proposal would, if their added cost resulting from the requirement to offer qualified coverage exceeds 3 percent of their total payroll, be entitled to a Federal subsidy of part of the excess for the first 5 years of the program, as shown below:

Year of program	Percent of excess over 3 percent
First.....	80
Second.....	70
Third.....	60
Fourth.....	50
Fifth.....	40

The subsidy could be taken as a cash payment or as a credit against Federal income tax. In the latter case, tax credits unused in a year could be carried forward for the next 5 years.

The DHEW would conduct a continuing study of the effects of the coverage requirements on employers, especially on small employers. The study, which would be published annually, would consider the need to continue or modify the subsidy and alternative methods of providing it, if needed.

An employee whose premium contribution is greater than it would be under the plan for the nonemployed and self-employed (because his family is a low-income family) would receive a subsidy for the amount of the difference. The subsidy could be taken as a credit against income taxes or as a certificate of entitlement in the same way as under the plan for the nonemployed and self-employed.

INSURANCE FOR THE UNEMPLOYED

A special program would be established to continue health insurance coverage under employee plans for workers who become unemployed. To be eligible under this program a worker must be eligible for benefits under a public unemployment insurance program and be a member of a family in which no other member is eligible for family coverage under an employee plan. Coverage under the program for the unemployed would begin when the regular coverage under the employee plan has terminated--that is, 30 days after termination of employment--and would continue during the period the worker continued to be eligible for unemployment insurance and for 30 days thereafter.

The newly unemployed worker would apply for coverage under the program to his last employer or to his employer's insurance carrier. By agreement with the DHEW, State unemployment insurance agencies would determine eligibility under the program and certify it to employers and carriers. The DHEW would pay the entire premium to the carrier, or to the employer if the employer had already paid the premium. The premium cost would be financed from Federal general revenue funds.

A worker who has exhausted his eligibility under the program for the unemployed could, under special provisions of the plan for the nonemployed and self-employed, immediately join that plan and receive a 100-percent subsidy of the premium cost of qualified coverage until the end of the calendar year. If he continued to be unemployed beyond the end of the year, he could enroll under the regular provisions of the plan for the nonemployed and self-employed. Of course, coverage under

the special or regular provisions of the plan for the nonemployed and self-employed would end when a member of the family becomes eligible for family coverage under an employee plan.

PLAN FOR THE NONEMPLOYED AND SELF-EMPLOYED

The plan is designed to provide qualified coverage for nonemployed persons, the self-employed, and others. It would make available the purchase of qualified private health insurance with Federal subsidy of the premium cost, varied according to family income, in the form of a tax credit or a certificate of entitlement.

Coverage

Coverage under the plan for the nonemployed and self-employed would be available to the entire population except for persons and their families eligible for coverage under qualified employee plans. Persons could enroll in the plan within 60 days of becoming eligible for it or during open enrollment periods which would be held at least every 6 months.

Benefits

The amount of the Federal subsidy would be based on the premium cost of a qualified policy and the income tax payable by the family during the past year. The subsidy would be equal to the full premium cost for families with no tax liability, and would be slowly graduated downward (for each $10 in tax liability) with a subsidy of 10 percent available to those with taxes of $891 or more. This schedule of subsidies is applicable to all types of returns including individual returns and joint returns of married couples. In computing the amount of tax liability for a family, the taxes of all members of the family including dependents would be combined (even though separate returns were filed). The family is defined in the same way as under the employee plan.

The following tabulation shows the percentage of the premium cost that would be subsidized at selected levels of tax liability, as shown in the bill. Also shown is the equivalent adjusted gross income corresponding to the tax liability for a family of four taking the standard deduction under the law applicable for 1975.

Tax liability	Adjusted gross income	Tax credit (percent)
None	$4,900 or less	100
$100	$5,600	90
$300	$6,950	70
$500	$8,200	50
$700	$9,300	30
$891	$10,300 or more	10

Under a special provision of the bill designed to give consideration to income not subject to tax, the percentage of tax credit (calculated as described above) would be reduced 1 percentage point for each $100 of nontaxable income, but not below 10 percent. Pension, annuity, and social security income would be included as nontaxable income for this purpose only to the extent that this income exceeded $4,000.

As discussed previously, persons exhausting coverage during a year under the program for the unemployed would receive a 100-percent subsidy of the premium cost until the end of that calendar year, regardless of family income or tax liability.

As under the employee plan, the health insurance policies must be noncancellable, guaranteed renewable, and pay for pre-existing conditions. The services and coinsurance requirements would be the same, except that the coinsurance requirements would be waived entirely for families receiving a 100-percent subsidy of premium cost (namely, those with no tax liability and those under the special provision for the unemployed). Supplemental coverage would be available for persons under Medicare in the same manner as under the employee plan.

Administration

Person under this plan could elect to receive the subsidy in the form of a tax credit or a certificate of entitlement. To receive a certificate of entitlement, persons would apply to the Department of Health, Education, and Welfare on a form indicating their family income, the place their tax return was filed and other information. DHEW would issue a certificate showing the allowable subsidy and this certificate would be accepted by carriers toward payment of the premium for qualified insurance. The certificates would be redeemed by the DHEW from the carriers.

Insurance carriers would be required to assist persons in preparing applications for certificates and to place the insurance in effect pending final determination and issuance of the certificate. The DHEW would guarantee payment of the premium while the application was pending.

As an alternative, persons could purchase a qualified policy with their own funds and take a credit against taxes on their next income tax return. Those with tax liability less than the amount of the credit, who choose this method, could claim the unused credit like an overpayment of taxes and receive a refund.

Financing

The maximum premium rate for qualified policies under the plan could not exceed 125 percent of the average rate for employment groups of 100 or more under the employee plans in the State. Insurance carriers which offer coverage under employee plans would be required to offer policies under this plan. They could do so by themselves or in combination with other carriers and could also be required to participate in an assigned risk pool, as described later.

A self-employed person who purchases a qualified policy under the plan for the nonemployed and self-employed could, if he meets the additional condition of contributing as an employer toward the premium of an employee plan, deduct 65 percent of his own premium cost as a business expense on his business tax return. In this case, he could not also take his expense as a medical expense deduction on his personal return.

Certificates of entitlement would be redeemed from a trust fund called the federal health insurance redemption fund. Funds from Federal general revenues would be deposited in the fund in sufficient amount to meet the obligations of the fund.

PROVISION AFFECTING ALL PLANS

Administration

A health insurance advisory board would be established, consisting of the Secretary of HEW (chairman), the Commissioner of Internal Revenue, and 13 additional members (including 6 M.D.'s, 1 D.O. and 1 D.D.S.) appointed by the President with Senate approval. The board would establish the regulations for the program and issue standards for use by State insurance departments in determining whether insurance carriers and policies are qualified. In consultation with carriers, providers, and consumers, it would study methods to maintain the quality of care and the effective use of resources through utilization and peer review.

It would also evaluate the effectiveness of the program, especially the utilization review procedures of carriers and professional associations, and recommend changes in the law.

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine, the manner in which services are provided, the selection or compensation of officers and employees of providers of service, or the operations of providers of service.

The DHEW would conduct a continuing program of public education on the need for protection against expenses of illnesses and the availability of insurance under qualified employee plans and plans for the nonemployed and self-employed.

Reimbursement

Reimbursement for hospital services would be determined by State agencies after consultation with representatives of the providers in the State. Methods of payment could include prospective rate methods and these could be based on budget review, negotiated rates, target rates, formula negotiation, and other methods. Payment for physicians' services would be made on the basis of usual and customary or reasonable charges.

Qualified policies and plans must provide for coordination of benefits to avoid duplication of benefits or payment of the coinsurance.

Insurers

To be a qualified carrier under the plan, a carrier must be authorized to operate by the State and the State must determine that it meets the requirements of the program. It must provide qualified health insurance or qualified supplemental health insurance under both the employee plan and the plan for the nonemployed and self-employed. It must provide at least two 30-day open enrollment periods each year at intervals of not more than 6 months. The carriers must also establish procedures to make available statistical information and procedures to protect the confidentiality of medical records.

Assigned risk pools would be established in those States where the State insurance department determines that a pool is necessary to assure coverage for everyone. Qualified carriers would be required to participate in the pool and accept risks assigned to it.

Other Provisions

A person who accepts a subsidy under the employee plan or under the plan for the nonemployed and self-employed could not also take his premium cost as a medical expense deduction on his personal income tax return.

In legal cases against a provider for damages for injury or death arising out of care or treatment of a patient (such as a malpractice case), no liability would be recognized for the costs of services covered under the proposed program (if the services were performed under this program or under Medicare or Medicaid).

DOWNING BILL

The "Health Care Insurance Act of 1973" was introduced by Representative Thomas N. Downing of Virginia as H.R. 363. It is identical to a bill introduced in the 93rd Congress by Representatives Richard H. Fulton of Tennessee and Joel T. Broyhill of Virginia as H.R. 2222 and by Senator Vance Hartke of Indiana as S. 444.

General Concept and Approach

The Medicredit proposal would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified private health insurance policies. A qualified policy must provide specified basic and catastrophic benefits and the maximum amount of the tax credit would be based on the premium cost of this policy. The amount of the credit for a family would be graduated on the basis of the family's income tax liability (the amount of tax payable for the year) with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. All persons could voluntarily elect coverage under the plan, except those age 65 and over.

Coverage of the Population

Since all families and individuals potentially subject to the Federal individual income tax would be eligible, virtually the entire population could voluntarily elect coverage under the plan. However, persons age 65 and over (who would remain under the Medicare program) would not be covered by the proposal.

Benefit Structure

The amount of the tax credit would be based on the premium cost of a qualified policy which provides specified basic and catastrophic benefits. For the catastrophic benefits, the amount of tax credit would be equal to the full premium cost applicable to those benefits. For the basic benefits (which constitute the major part of the benefit package) the amount of the credit would be equal to the premium for persons with no tax liability, and would be slowly graduated downward (for each $10 increase in tax liability) with a credit of 10 percent available to those with taxes of $891 or more.

This schedule of credits is applicable to all types of returns including individual returns and joint returns of married couples. In computing the amount of tax liability for Medicredit purposes, the taxes

of dependents would be included (even though the dependent files an individual return). Also, the tax liability of a husband and wife filing separate returns would be combined.

The following tabulation shows the percentage of the premium cost of the basic benefits that could be taken as a credit at selected levels of tax liability, as shown in the Medicredit bill. Also a column has been added showing the equivalent adjusted gross income, for a family of four taking the standard deduction at specified tax liability levels, for 1975.

Amount of tax liability	Amount of adjusted gross income	Amount of tax credit (percent)
None	$4,900 or less	100
$100	$5,600	90
$300	$6,950	70
$500	$8,200	50
$700	$9,300	30
$891	$10,300 or more	10

Individuals or families with no tax liability would receive a voucher certificate which would be accepted by a carrier for the purchase of a qualified insurance policy. Those with a tax liability less than the amount of the credit could receive a certificate, or claim the additional credit like an overpayment of taxes.

Taxpayers who elect a tax credit could not claim the health insurance premium as a medical expense deduction for income tax purposes.

Employer-Employee Plans

Under present law, an employer may take the full cost of his premium contributions for health insurance for his employees as a business deduction. Under the proposal, he must maintain a qualified plan (providing the specified benefits) to continue to take a full deduction; otherwise, only one-half the contributions could be taken.

The employee, in computing the amount of premiums against which he may take a tax credit on his personal tax return, would count 80 percent of the employer contribution to a qualified plan as if it were his own contribution.

Qualified Insurance Policy

As indicated, a qualified policy under the plan would offer specified basic benefits and catastrophic benefits. The policy would need to be

guaranteed renewable and benefits could not be refused because of pre-existing medical conditions. The benefits of the policy are shown in table 1.

General dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. (For example, in second year to age 7, in third to age 8.) Emergency dental services and certain oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations. The physicians and outpatient service benefits includes unlimited physical examinations, innoculations, well-baby care, and psychiatric care.

The family's total payment for coinsurance under the basic coverage for physicians', laboratory, and X-ray services combined would be limited to $100 annually (20 percent of the first $500). An additional limit of $100 annually would apply to hospital outpatient, home health and ambulance services combined, and a separate $100 limit for dental care.

Benefits under the catastrophic coverage (which applies to additional hospital days, prosthetics and blood) would first become payable after a corridor deductible (out-of-pocket payment) which would vary according to family income. Cost sharing payments made under the basic plan would be creditable toward meeting this corridor deductible. The deductible, which would be based on the family's taxable income (after exemptions and deductions) including the income of dependents, would be equal to 10 percent of taxable income.

Administration

Persons would purchase qualified health insurance from private health insurance carriers who would issue policies, collect premiums (or vouchers), and process claims for benefits.

State insurance departments would determine whether insurance carriers and policies are qualified under the Medicredit program. Carriers would be required to participate in assigned-risk pools and accept the poor risks assigned them by the State insurance departments.

The Department of Health, Education, and Welfare would issue and redeem the health insurance voucher certificates. Also at the national level, a health insurance advisory board would be established, consisting of the Secretary of Health, Education, and Welfare (chairman), the Commissioner of Internal Revenue, and nine additional members (the majority of whom would be physicians) appointed by the President with Senate approval. The board would establish the regulations for the administration of the program and issue the Federal standards to be

TABLE 1.--DOWNING BILL: Benefit provisions under a qualified insurance policy 1/

Type of service	Basic benefits	Catastrophic benefits 2/
Institutional services:		
Hospital inpatient care.	60 days a year with a $50 deductible for each stay.3/	Unlimited additional hospital days.
Skilled nursing.....	2 days in a skilled nursing facility may be substituted for 1 day of hospital care, with a $50 deductible for each stay.	30 additional days.
Personal services:		
Physicians' services Laboratory and X-ray ..	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Hospital outpatient care Home health services.... Ambulance service.....	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Dental services.....	As specified.5/ (20% coinsurance, with a limit per family of $100 a year.)	4/
Other services and supplies:		
Medical appliances.....	---	Prosthetic devices.
Blood.....	---	Outpatient blood and plasma (after the first 3 pints.)

1/ For persons on Federal cash assistance, any deductibles and coinsurance would be met by the State under Medicaid.

2/ Payable after family meets a secondary deductible of 10% of the family's taxable income reduced by the amount of copayments made by that family for covered basic benefits.

3/ Includes inpatient blood and plasma (after the first 3 pints).

4/ Services are provided under basic coverage without limit.

5/ General dental care for children; emergency dental care and oral surgery for all persons (see text).

used by the State insurance departments in determining whether insurance carriers and policies are qualified. In consultation with carriers, providers, and consumers, it would study methods to maintain the quality of care and the effective use of resources through utilization and peer review.

Relationship to Other Government Programs

The bill provides that benefits claimed under Medicredit may not be duplicated under other programs financed by the Federal Government. The Medicredit proposal would affect the Medicaid and other assistance programs by covering those services for the low-income population that were provided by the assistance programs.

Financing

The Medicredit program would be financed from Federal general revenues. The granting of tax credits would result in a reduction in Federal income tax receipts and the voucher certificates would be redeemed from general revenues through a special trust fund created for this purpose.

Standards and Reimbursement of Providers of Services

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine, the manner in which services are provided, the selection or compensation of providers of services, or the operations of providers of services.

The insurance carriers participating in the program would reimburse the providers of services. The bill requires that payment for services under the program must be on the basis of usual and customary charges.

Delivery and Resources

There are no specific provisions regarding these subjects.

BENNETT BILL

The "Health Care Insurance Act of 1975" was introduced by Representative Charles E. Bennett of Florida as H.R. 93.

The bill is similar to H.R. 363 introduced by Representative Thomas N. Downing of Virginia, described earlier.

The major differences between the two bills are that the Bennett bill--

(1) does not cover home health services and dental care,

(2) uses different groupings of services for the purpose of limiting the total coinsurance payable, and

(3) bases the formula for determining the "corridor deductible," after which catastrophic benefits become payable, on varying percentages applied to specified income intervals (rather than a uniform 10 percent of income).

BROCK BILL

The "Medical Expense Tax Credit Act" was introduced by Senator William E. Brock, III of Tennessee as S. 600.

General Concept and Approach

The proposal would provide tax credits against personal income taxes when medical expenses exceed a specified percent of family income. The tax credit would ordinarily be claimed on the regular income tax return.

Coverage of the Population

All individuals and families potentially subject to the income tax, or virtually the entire population, could file for tax credits under the proposal.

Benefit Structure

A credit against personal income taxes would be allowed if medical expenses of the family members included on the tax return exceeded 15 percent of modified adjusted gross income. (Adjusted gross income would be modified by reducing it by the personal exemption of $750 for each family member and making other modifications described later.) The amount of the credit would be 85 percent of the medical expenses which exceed the 15 percent of income. Thus the proposal in effect incorporates an income-related duductible and a constant coinsurance rate.

For example, for a family of four with adjusted gross income of $9,000 ($6,000 after personal exemptions of $750 each) and medical expenses of $2,000, the tax credit would be calculated as follows:

Medical expenses	$2,000
15% of modified family income (of $6,000)	900
Difference	$1,100
Tax credit (85% of $1,100)	$935

Adjusted gross income would be modified (in addition to deducting personal exemptions) by adding the capital gains and interest on those government bonds which are excluded from adjusted gross income under present tax law.

The medical expenses included for the tax credit would be out-of-pocket expenses paid or incurred. The definition of medical expenses would be the same as for medical deductions under the present income tax law, with two exceptions.

The special limitation on deduction of drugs and medicines under present law would be removed for tax credit purposes. The special limitation on deduction of health insurance premiums would be modified so that taxpayers with adjusted gross income of less than $10,000 could include the full cost of premiums for tax credit purposes and taxpayers with income above $10,000 could take one-half the cost. The supplementary medical insurance premium under Medicare would be considered as health insurance premiums.

Administration

Persons would be required to file an income tax return to claim a credit. The full amount of the credit will always be payable, without regard to the amount (if any) of taxes. Procedurally, the credit would be applied against current-year taxes and then against the preceding year, but the full credit would be given upon filing. (In this way, the proposal is similar to some negative income tax proposals.)

Relationship to Other Government Programs

The President would study the adequacy of the tax credit proposal in meeting the health needs of the Nation and recommend whether Medicare, Medicaid, and other Federal medical assistance and health care programs should be terminated, reduced, or changed.

Financing

The proposal would be financed from Federal general revenues. The bill repeals the present medical expense deduction provisions of the income tax law.

Other Provisions

The bill includes no provisions concerning standards for providers, reimbursement, or health delivery and resources.

CLAWSON BILL

The "Basic Health Insurance Tax Credit and Medical Assistance Act" was introduced by Representative Del Clawson of California as H.R. 10562.

The bill would make available tax credits and deductions for medical care expenses and would permit States to administer their Medicaid program through private health insurance.

TAX CREDITS AND DEDUCTIONS

Under the tax credit provisions, the taxpayer could take a tax credit on his Federal personal income tax return equal to the premium cost of a qualified health insurance policy. The credit could apply to health insurance covering the taxpayer, his spouse, and dependents (including all dependents who can be claimed as an exemption under the income tax law), and, in addition, any other persons who are needy or indigent as determined under Federal regulations.

The health insurance could cover all medical expenses for the diagnosis, treatment, or prevention of disease or for the purpose of affecting structures or functions of the body and would include medicines and drugs. (This definition is similar to the present medical expense income tax deduction.) The premium cost under the supplementary medical insurance part of the Medicare program could also be included.

Where an insurance policy includes both medical care and other types of coverage, only the amount of the premium attributable to medical care (as indicated by the insurance carrier) could be counted toward the tax credit. This amount allocated to health care must be reasonable compared to the total premium cost of the policy.

The tax credit could be taken against the taxes payable for the current year and could be carried back to the previous 2 years or carried forward to the following 2 years. In any case, the credit could be taken without regard to the amount of income tax payable for the year. If the credit is greater than the tax, the excess amount would be considered as an overpayment of tax.

Tax Deductions

The present provisions of tax law permitting deductions for medical expenses exceeding 3 percent of adjusted gross income would be eliminated. Instead, all medical expenses which exceed $500 for the year would be deductible except that expenses for insurance premiums would no longer be deductible. The allowable medical deduction could be taken for the current year or for the 2 preceding or 2 succeeding years.

The taxpayer could claim the deduction for expenses for medical care for himself, his spouse, and dependents (as defined under the tax law) and also for other persons who are needy or indigent as determined under

Federal regulations. Contributions for medical care of needy or indigent persons made through a charitable organization could be claimed as a charitable deduction.

Administration

The Treasury Department would establish the regulations for the program. These regulations could not limit a person's right to choose his own licensed health provider and his place of treatment.

Financing

The costs of the program would in effect be financed by Federal general revenues.

Relationship to Other Government Programs

The President would study the adequacy of the tax credit provisions as an alternative to the Medicare, Medicaid, and other Federal medical assistance and health programs and would recommend to the Congress whether these programs should be changed, reduced, or terminated.

CHANGES IN THE MEDICAID LAW

As an alternative to other methods of administering their Medicaid programs, States could elect to provide Medicaid benefits in the form of coverage under private health insurance to all their Medicaid beneficiaries or designated classes of beneficiaries. Under this option, the State would arrange private insurance for their beneficiaries and this insurance must provide at least the same health benefits as would be available under the regular State Medicaid program. Also any cost sharing, premiums, or other fees charged the beneficiaries could not be greater than under the regular program.

A State which selects this option would need to modify its State Medicaid plan to implement the option including, for example, provisions for payment of premiums on behalf of Medicaid beneficiaries. The modified State plan must be approved by the DHEW as (1) fulfilling the objectives of the Medicaid law and (2) not resulting in increased payment by the Federal Government for the State Medicaid program.

LONG-RIBICOFF--WAGGONNER BILL

The "Catastrophic Health Insurance and Medical Assistance Reform Act" was introduced by Senators Russell B. Long of Louisiana and Abraham A. Ribicoff of Connecticut as S. 2470 and by Representative Joe D. Waggonner of Louisiana as H.R. 10028.

General Concept and Approach

A catastrophic illness insurance plan would provide health benefits for persons in the general population who have incurred unusually large health expenses. A medical assistance plan would cover the low-income population through a national plan with uniform eligibility standards. The two plans would be administered in a manner similar to the Medicare program. The proposal would also establish a program of Federal certification of private health insurance to encourage insurance carriers to make available improved basic private insurance. The three programs would supplement and be coordinated with each other.

CATASTROPHIC HEALTH INSURANCE--GOVERNMENT PROGRAM

The catastrophic plan would provide benefits to persons who have already incurred long hospital stays or large medical bills. The program, which would cover all of the population, would be administered through the Medicare program and be financed by special payroll taxes. Employers could voluntarily elect to provide the catastrophic coverage for their employees under a private plan, as an alternative to the government-administered program, and a similar option would be available to self-employed persons. These options are discussed later.

Coverage

All residents of the United States including permanent resident aliens would be eligible for benefits under the program without regard to their contributions to the program.

Benefit Structure

The program would cover the same services as the Medicare program and as under Medicare the services would be provided under separate hospital insurance and medical insurance parts of the program, as shown below.

Hospital Insurance

- Hospital inpatient care
- Skilled nursing facility services
- Home health services

Medical Insurance

Physicians services

Laboratory and X-ray

Immunizations

Home health services

Outpatient physical therapy

Medical supplies and appliances

Ambulance services

The three types of services under hospital insurance would be covered after the patient has received 60 days of inpatient hospital care during a calendar year. Days spent in the hospital during the last 3 months of a year would count toward the 60-day requirement for the next year. Hospital care would count toward the deductible even if covered by another public health plan or by a private plan. Once the deductible is met, the period of eligibility for covered services (the benefit period) would continue indefinitely until the patient has been out of both a hospital and skilled nursing facility (SNF) for a consecutive period of 90 days. If so, the patient would need to meet another 60-day hospital deductible before becoming eligible for benefits again.

During the benefit period, there would be no limit on the number of covered hospital days or home health visits. However, services in a skilled nursing home would be limited to 100 days in a year and the number of available SNF days would be reduced by any days spent in a SNF during the year (even though those days were not covered by the catastrophic program).

Eligibility under the medical insurance part of the program would be on a family basis. The services under medical insurance would be covered for all members of a family after the members together have incurred expenses of $2,000 in a calendar year. Expenses incurred in the last 3 months of a year would be included toward payment of the deductible for the following year. Only expenses for the types of services covered under the medical part of the proposal would count toward the $2,000 deductible. Expenses covered under another public program or a private health plan would count toward the deductible.

Once the deductible is met, the period of eligibility for services (the benefit period) would continue indefinitely until the family has incurred expenses of less than $500 in a 90-day period. During the benefit period, all the services under medical insurance would be covered without limitation on the amount of services.

The amounts shown above for the deductible and the benefit period ($2,000 and $500 respectively) would apply only in the first year of the program. Each year thereafter, these amounts would be adjusted based on the increase in the physician fee component of the Consumers Price Index.

For this provision, a family is defined as two or more persons related by blood, marriage, or adoption living in the same residence including the spouses and their dependents. Children under age 22 absent from home because they are full-time students would be considered members of the family.

Special Provisions for Mental Illness

Special provisions would apply to coverage of mental conditions. The hospital insurance part of the proposal would include coverage of inpatient hospital care for mental illness provided in general and mental hospitals. To be covered, these services must constitute active care and treatment and must be provided by an accredited medical institution. Partial hospitalization (such as day or night care) would be covered in an accredited medical institution or a qualified community mental health center.

Mental health care services on an outpatient basis would be covered under the medical part of the program. Under a special provision, the amount of expenses for outpatient mental illness care which could be credited toward meeting the $2,000 deductible would be limited to a maximum of $500. Once the medical deductible is met, outpatient care would be covered with no limit on the number of visits when provided by a qualified community mental health center. Care by a private psychiatrist would be covered, but limited to a maximum of 5 visits during a 12-month period, with additional visits covered only if approved in advance by a professional review organization as being necessary to avoid institutional care.

The requirements for participation as an accredited medical institution and a qualified community mental health center would be determined under regulations to be established by the DHEW.

Experimental and Complex Treatments

The DHEW would issue regulations establishing standards and criteria designed to assure that experimental and unusually extensive or complex treatments would be covered only when they are appropriate to the health needs of the patient. These regulations could apply to both the hospital and medical parts of the proposed program.

Relationship to Other Programs

Benefits for services under the catastrophic program would be payable without regard to coverage of the services under other public programs or private plans. It is specifically indicated that the benefits would be primary to those of the medical assistance part of the program. However, an exception is made for skilled nursing home care which, when also covered by the Medicare program, would be paid by Medicare.

Financing

The program would be financed by special taxes on employers and self-employed persons. Employers would pay a tax of 1 percent of payroll. The amount of wages subject to tax (the wage base) would be the same as under the social security program. The types of employment taxable would also be the same but, in addition, Federal, State, and local governments would be covered. Private employers contributing to the program would be allowed a tax credit against their Federal income tax of 50 percent of the amount of their contributions. (Under special provisions, State and local governments would also obtain a return of one-half of their contributions.) The contributions could not be taken as a business deduction on the tax return as under present tax law.

State and local governments would contribute under special arrangements under which the State would enact a law providing for payment of the tax, on the same basis as for private employers, by the State government and by local governments within its jurisdiction. The State law must be approved by the Department of the Treasury which would also oversee compliance with these provisions. Unless a State has enacted an approved law, its residents would not be eligible for benefits under the catastrophic insurance or medical assistance programs.

Self-employed persons would be subject to a tax of 1 percent of earnings, with the earning base and types of self-employment taxable being the same as under social security. These self-employed contributors would be allowed a credit against their income tax of 50 percent of their contributions.

Thus, in effect, the program would be financed roughly one-half from special taxes and one-half from Federal general revenues.

CATASTROPHIC ILLNESS INSURANCE--PRIVATE PLANS

At their option, employers could establish approved private plans as an alternative method of providing coverage for their employees. An approved plan must provide the same catastrophic benefits as the government

plan and must meet specified requirements concerning coverage, administration, financing, and other matters. Employees covered under an approved plan would receive the catastrophic benefits under that plan and would not be eligible under the government program.

Coverage

All employers subject to contributions under the program, including Federal, State, and local governments, would have the option of providing coverage through a private plan. A private employer plan must cover all employees of the firm or organization except part-time (less than 25 hours a week) and temporary employees and employees eligible under the Medicare program. However, these employees could be covered on an optional basis. New employees must be covered at the beginning of the first month which occurs more than 30 days after the start of employment. Coverage under the plan would continue for 90 days after the termination of employment, but would end as soon as the employee obtained coverage under another approved plan. (An employee who remains unemployed for more than 90 days would be automatically covered under the government-administered plan.) Employer plans would be required to cover the employee and members of the employee's family.

Benefits

Employer plans must provide the same catastrophic benefits as the government plan. It could also provide other benefits so that an existing plan which already includes the catastrophic benefits, or is revised to include them, could qualify as an approved plan. The plan could exclude services covered under workmen's compensation programs.

Administration

Employers could provide benefits under a private plan by insuring with an approved health insurance carrier. The plan could also be self-insured and, in this case, the employer would need to give proof of financial and administrative ability to operate the plan and could be required to deposit an indemnity bond or securities as collateral to assure payment of benefits in case of default. Private plan coverage could be implemented through multi-employer plans (plans which arrange health insurance for employees of two or more employers in the same industry) or plans operated under trust of trade association arrangements.

All plans would need to be approved by the DHEW. The Department could include on the applications for approval provisions for recommendations of approval by State insurance departments and could use these recommendations in expediting approval.

Plans could include provisions for coordination of benefits (provisions designed to prevent duplicate payments for the same services) if the DHEW approved them as consistent with prevailing practice in the health insurance industry.

Requirements for Insurance Carriers

Insurance carriers would need to be approved by the DHEW to participate in the catastrophic program. Various types of profit and nonprofit organizations could qualify as approved carriers, but not government agencies. The following provisions and requirements would apply to approved carriers.

(1) The carrier must offer catastrophic health insurance on both a group and individual (nongroup) basis in each State in which it does health insurance business. The policies must be noncancellable and guaranteed renewable.

(2) The carrier must establish procedures, approved by DHEW, to assure payment of claims in case it discontinued its catastrophic business or lost its status as an approved carrier.

(3) The carrier must establish procedures for determination (allowing or disallowing) of claims which (a) comply with the requirement of the 1974 Employee Income Security Act, (b) are consistent with the procedures used in its regular health insurance business, and (c) are at least as favorable to claimants as the procedures used in the government-administered program. To assist carriers in meeting the latter requirement, the DHEW would provide them with reasonable access to claims data from the government program.

(4) Carriers would be permitted to use methods of payment of providers and arrangements with providers they use in their regular business (and would not need to use the methods and arrangements of the government plan).

Carriers would be permitted to participate in insurance pools, reinsurance arrangements, and related activities in offering and administering catastrophic insurance. The bill would suspend Federal, State, and local antitrust and related laws which now make certain arrangements of these types illegal.

An actuarial committee consisting of five qualified actuaries, of whom only two could be persons employed by insurance carrier, would be appointed by the DHEW. The committee would review practices of insurance carriers in marketing and premium rating of approved plans to determine whether these practices unduly restrict the availability of approved plans. It would also prepare the annual table of values of catastrophic health insurance, described below.

The employer would be required to pay the entire cost of the catastrophic benefits included in a health insurance plan and employees could not be required or permitted to contribute toward this cost.

The determination of the premium amount for the catastrophic insurance must be based, at least in part, on the pooling of risk among employer plans.1/ The premium could be based entirely on a pooled risk method. Alternatively, this method could be used only to determine the part of the premium which applies to benefits exceeding a specified amount for any one policy. This specified amount could be any amount agreed between the employer and the carrier. The balance of the premium could be based on another rating method.

The carrier must state separately to the employer the premium amount for the required catastrophic coverage included in an employer plan and must do so in a manner which will facilitate comparison with the amount allowable as a tax credit.

Employers with private plans would be subject to the regular taxing provisions of the bill (the 1 percent payroll tax and the 50-percent credit against income tax), but the amount of the tax and credit would be adjusted. The basis for this adjustment would not be the amount of the employers actual premium payment, but rather an amount indicated in an annual table of values of catastrophic health insurance. This table would show the actuarial value of catastrophic health insurance in each State. The actuarial value for a State would be based on the estimated cost and utilization of services, claims experience, administrative expenses, and other relevant factors. The State-by-State variations would be expected to reflect cost differences due to geographic factors and the age and dependency characteristics of the population. The table of values would be prepared by the actuarial committee, described above, and would need to be approved and certified by the DHEW.

For an employer with a private plan, the amount of the actuarial value for his State would be considered as the amount of his payment toward the 1-percent payroll tax. Thus, the tax payable would be reduced, up to its full amount, by the amount of the actuarial value. Similarly,

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1/ Under the pooling-of-risk method of determining premium rates, the premium rate is based on the average benefit experience of a large number of plans in a specified area. This method is sometimes referred to as community rating. The predominant rating method now used for group health insurance is basing the rate for a group plan separately on the benefit experience of the group. This method is sometimes called experience rating.

the 50-percent tax credit would be taken against the combined total of the tax payable (if any) and the State actuarial value. Neither the tax contributions nor premium payments could be taken as a business deduction on the income tax return.

Self-Employed Plans

Self-employed persons could voluntarily establish a private catastrophic plan on a basis similar, in many ways, to employer plans. Such a plan would cover the self-employed person and the members of his family and persons covered under them would not be eligible for benefits under the government programs.

Like employer plans, self-employed plans could be obtained by purchasing an approved health insurance policy from an approved carrier. The policy must include the same catastrophic benefits provided under the government plan, but could also included other benefits.

The taxing provisions would also parallel those for employer plans. Self-employed persons with a private plan would continue to be subject to the 1-percent tax on self-employment income, but the amount of this tax would be reduced by the actuarial value of catastrophic health insurance established for his State, up to the full amount of the tax. He would also take a tax credit of 50 percent of the combined total of the remaining tax payable (if any) and the State actuarial value. Neither the tax nor the premium could be taken as a tax deduction.

MEDICAL ASSISTANCE PLAN FOR LOW-INCOME PEOPLE

The medical assistance plan for low-income and medically indigent persons would be administered through the Medicare program. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The program would be financed jointly from Federal and State general revenues.

Coverage

The benefits of the program would be available to citizens and aliens admitted for permanent residence whose annual family income is below the following amounts without regard to their age, family status, employment, or State of residence.

Individual	$2,400
Family of two	3,600
Family of three	4,200
Family of four	4,800
Family of more than four	4,800 plus $400 for each additional member

A family is defined as two or more persons related by blood, marriage, or adoption living in the same home.

The types of income counted for eligibility would include both earned and unearned income--including wages, self-employment income, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, alimony and inheritances. Excluded from consideration are small gifts and certain funds received for educational purposes such as scholarships, loans, and fellowships.

By regulation, procedures may be established under which specified gross amounts of income from a trade, business, or farming may be considered sufficiently large to disqualify families even though their income technically falls within the limits. These procedures could be similar to those under the present supplemental security income (SSI) program for the aged, blind, and disabled.

In addition, families who meet all the requirements for eligibility under a State Medicaid program at the time the assitance plan started would automatically be eligible under the plan if their income was within 105 percent of the States' income requirements for Medicaid.

Spend-Down Provisions

Families with income higher than the specified amounts could still qualify for benefits under the "spend-down provision." Under this provision, the family's income for the purpose of eligibility is considered its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket, that is, expenses not covered by a private or government plan. (Thus a family of four with annual income of $5,000 would qualify after they incurred out-of-pocket medical expenses of $200.) These medical expenses could be expenses actually paid or the reasonable charge for the services, if not yet paid. The types of medical expenses considered for computing the spend-down include a broad range of services including all the types of services covered under the proposal, and many not covered such as dental care, prescribed drugs, and eyeglasses. It would also include expenses for health insurance premiums and one-half of the taxes and/or premiums paid by a self-employed person under the catastrophic health insurance provisions. Eligibility under the spend-down provision may be determined on a prospective basis if the future income is determinable and a family member can be expected to need institutional care.

Determination of Eligibility

While eligibility is based on the family's annual income as indicated above, the determination of its annual income would be based on its rate of income in the 2-month period before the date of application for benefits and its estimated prospective income for the 2 months after application. Prospective income would be based on current income and other relevant factors.

When an application is approved, eligibility for benefits would usually start the first day of the month in which the application is filed, but eligibility could be extended backward for as many as 3 months before the month of application, if the family was qualified during this earlier period and incurred covered medical costs.

In most cases, an application would be filed to establish eligibility for a coverage year which would be the 12-month period beginning April 1st of each year. Once approved, eligibility would continue throughout the coverage year unless family income increased to an amount more than 20 percent above the income limit for the family size. Also, a change in eligibility resulting from one member leaving the family would be disregarded during the coverage year.

If at the time eligibility for a family terminated, a member of the family was an inpatient in a hospital or a skilled or intermediate nursing facility, eligibility for that member would continue until he was discharged.

Benefits

The benefits of the program are listed below. There are no limits on the amount of services or any cost sharing required, except as indicated.

Institutional Services

Inpatient hospital services: 60 days in benefit period.
Skilled nursing facilities.
Intermediate care facilities.

Personal Services

Physicians' services: $3 copayment for each of first 10 outpatient visits per family.
Laboratory and X-ray.
Home health services.
Prenatal and well-baby care.
Family planning, counseling and supplies.
Periodic examinations: For children under age 18.
Outpatient physical therapy.
Immunizations: By regulation.

Other Services and Supplies

Medical supplies and appliances.
Ambulance services.

Services in an intermediate care facility would be available to patients who do not require services in a hospital or skilled nursing facility, but who have a physical or mental condition which requires care (in addition to room and board) available only through institutional facilities.

The types of mental health services covered under the medical assistance program would include the same services as under the catastrophic program (including inpatient hospital care, partial hospitalization, and outpatient services) subject to the same conditions and limitations, except of course for the deductible requirements. In addition, care for mentally retarded persons in public institutions would be covered if the patient is receiving active treatment; this coverage would be provided under the provisions applicable to intermediate care facilities.

The mental health benefits under medical assistance would also cover prescription drugs provided on an outpatient basis. (Outpatient drugs are otherwise not covered under the proposal.) The drugs must be prescribed by a physician who could be a physician in an approved mental health center or a private psychiatrist. In either case, the drug would be covered only if the physician determines that the patient can be expected to need institutional care unless he receives the prescribed drug. The covered drugs would be limited to those included on a list, established by DHEW, which would indicate the mental condition for which it is effective and the appropriate dosage.

Copayment

The $3 copayment requirement would apply to persons under the Medicare program only to the extent this amount is less than the regular cost sharing required under Medicare. The $3 copayment would not apply to any physician visits for well-baby care, health examinations for children, or family planning services.

A special copayment requirement would also apply to individuals, who are not a member of a family, after the 60th continuous day spent in a long-term facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

Other Benefits

For persons under the Medicare program, the medical assistance program would pay the cost of the premium required to enroll in the supplementary medical insurance part of Medicare. For self-employed persons subject to the tax on earnings under the catastrophic insurance provisions, the medical assistance program would pay one-half of the amount of these taxes and, for those self-employed electing a private plan, one-half of the combined total of the State actuarial value and any remaining taxes due.

Relationship to Other Government and Private Programs

The present Medicaid program would be abolished and replaced by the new program. The Medicare program would continue.

The bill states its intent that the proposal not be construed to preclude States from providing protection for its residents against health costs, or individuals from obtaining (through collective bargaining or otherwise) protection against the cost of health services.

Payments under the medical assistance program would be secondary to all other government and private health programs and plans, including the proposed catastrophic program, Medicare, and workmen's compensation programs. Thus, where a person has coverage under another public or private plan, the medical assistance plan would pay only for services or any cost sharing not covered by the other plan. However, the medical assistance program would pay for services for its eligible beneficiaries in any State which has established a State medical assistance program designed to supplement the Federal program by providing higher income limits for eligibility.

Under penalty of law, the bill prohibits employers, who provide group health insurance for their employees, to exclude an employee because he is potentially eligible for benefits under the medical assistance proposal.

In the event a person was eligible for enrollment in a health insurance plan (for example, an employment-related group plan) under which the enrollees' contribution was 25 percent or less of the total premium, but did not enroll, benefits payable under the medical assistance plan would be reduced by $250 in a benefit period. A similar reduction would apply to persons who fail to enroll in the supplementary medical insurance (SMI) part of Medicare.

Financing

The program would be financed jointly by the Federal and State governments under an agreement between each State and the DHEW. Unless the State entered into this agreement, persons living in the State would not receive benefits under the proposed medical assistance or catastrophic programs.

The State contribution would be as follows: (1) an amount equal to the State's payments under the Medicaid program for those types of services covered under the medical assistance proposal and (2) again, for services under the new medical assistance proposal, one-half the payments it would have made under Medicaid if its eligibility requirements were the same as the medical assistance requirements (which of course would be applicable only to States with less liberal requirements). This formula would be based on the State's Medicaid spending and eligibility requirements in the year before the new medical assistance program began (or 1 year earlier, whichever is larger). The State contributions determined under this formula would be a fixed amount payable each year and would not rise in future years. The amount of this fixed payment would be reduced, each year, by one-half the State's expenditures in the year for kinds of health services not covered by medical assistance, if those services had previously been covered under the State Medicaid program and were of a kind eligible for Federal matching grants.

The balance of the cost of the proposed program would be financed from Federal general revenues. All funds would be held in a special medical coverage trust fund.

PROVISIONS AFFECTING BOTH PLANS

Administration

A new agency would be established in the DHEW, headed by an assistant secretary for health insurance, which would administer the Medicare program and the proposed catastrophic insurance, medical assistance, and private basic health insurance certification programs. It would also administer the professional standards review organization (PSRO) program which is now operated by the Public Health Service in DHEW.

The government-administered catastrophic program and the medical assistance program would be administered in a manner similar to the Medicare program and utilizing its administrative mechanisms. As under Medicare, private carriers would act as fiscal intermediaries responsible for administration of claims and payments to providers of services. The bill includes a provision, relating to the medical assistance program, authorizing the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency.

As under Medicare, State agencies would be responsible for determining whether providers of services meet the conditions for participation under the two proposed programs.

Persons eligible under the proposed medical assistance could enroll in a health maintenance organization and receive their services from these organizations, on a basis similar to that authorized for Medicare beneficiaries under P.L. 92-603.

Standards for Providers of Services

The two programs would apply the same standards for providers of services as under the Medicare program. (See Appendix.) For intermediate care facilities, which are not covered under Medicare, the bill requires the facility to be licensed under State law and meet regulations (to be established) concerning proper provisions of care, and safety and sanitation. It specifically includes qualified Christian Science sanatoria and institutions on Indian reservations.

Reimbursement of Providers of Services

Providers of services under the government-administered catastrophic program and the medical assistance program would be reimbursed on the same basis as under the Medicare program, except as noted below. Under Medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed on the basis of the reasonable cost of services. (Reimbursement of skilled nursing facilities under all three programs would be affected by new reimbursement provisions of the bill, described later.) Payments to physicians and certain other providers are determined on the basis of reasonable charges. In general, physicians may file and accept the Medicare payment as full payment (taking assignment). Alternatively, they may bill the patient, who files and receives the Medicare reasonable charge which may be less, but not more, than the physician's charge.

The bill specifies that for the medical assistance program the physician and other providers must accept the reasonable charge as full payment for services. This would also apply where the medical assistance payment is made to supplement a payment under another public or private insurance program. In this case, the reasonable charge for these services, as determined under the medical assistance plan, would be considered the full charge.

Of course, reimbursement under the catastrophic and medical assistance programs would be subject to the additional provisions relating to reim-

bursement under Medicare included in P.L. 92-603. This would include, for example, the limits on costs for institutional services recognized as reasonable (cost ceilings), limitations on payment for services in connection with disapproved capital expenditures, and limitations on payment where cost for an institution is less than its customary charges. The new limitations on increases in the amount of physicians' fees would also apply. It would of course also incorporate the health maintenance organization (HMO) provisions of P.L. 92-603 and the professional standards review organizations (PSRO) established to review the use and quality of services under Medicare and other programs under the social security law.

PRIVATE BASIC HEALTH INSURANCE CERTIFICATION

The stated purpose of the health insurance certification provisions is to encourage and facilitate the availability of basic health insurance at a reasonable premium charge. These provisions would (1) establish procedures for certification by the DHEW of private basic health insurance meeting specified requirements, (2) permit the marketing of this insurance through insurance pools and reinsurance and similar arrangements, (3) encourage the States to establish facilitation programs to assist in marketing certified insurance, and (4) permit the DHEW to offer directly certified health insurance in States where it is not available.

Requirements for Certification

To qualify as a certified policy, a health insurance policy must meet specified requirements concerning coverage, benefits, premium rates, and other matters.

Coverage Requirements

Policies based on family status must be made available--for a single individual, a married couple, and a family--each at appropriate premium rates. A family policy must cover dependent unmarried children under age 22 and must automatically cover any newborn and newly adopted children. A policy covering an employment group must meet the following additional requirements:

(1) continue coverage for at least 31 days after the end of employment,

(2) offer employees leaving employment a reasonable opportunity to convert to, or otherwise obtain, certified nongroup coverage, and,

(3) provide an annual enrollment period to permit enrollment of employees who previously failed to elect coverage.

Benefit Requirements

A certified policy must cover at least the following services, but could include additional services and could reduce the cost sharing requirements.

(1) Hospital inpatient care for at least 60 days, with a maximum deductible of $100 per person and no other cost sharing.

(2) Physicians services in the home, office, and institutional settings for at least the first $2,000 in physicians charges in the year. The maximum deductible could be $50 per person for a year (with credit toward the deductible given for expenses incurred in the last 3 months of the preceding year) and the maximum coinsurance rate would be limited to 20 percent of charges.

The policy could exclude routine physical examinations, cosmetic surgery, and charges for psychiatrists services exceeding $400 in a year.

Other Provisions

A group policy could not exclude any preexisting conditions (conditions or illnesses in existence at the time the patient was first enrolled under a policy) or require a waiting period before preexisting conditions are covered. A nongroup policy could not exclude preexisting conditions except pregnancy and could require a waiting period up to 90 days after enrollment.

A policy could exclude payment for charges to the extent they are not reasonably priced. A charge would always be considered reasonable if not higher than the allowable charge for the same service under the Medicare program or the proposed catastrophic program.

A policy could exclude payment for services covered under workmen's compensation programs, Medicare, and the proposed catastrophic program. It could also exclude services for which the patient has no legal obligation to pay, such as those provided by the VA.

Benefit-Premium Ratios

As one of the requirements for certification, the DHEW would establish, for each policy, a maximum ratio of the amount of benefits and other ex-

penses to the amount of the premium charged (similar to a retention ratio). In determining the ratios, consideration would be given to the nature of the carrier offering the policy, including its profit or nonprofit characteristics, and the number of subscribers in a group. For individual policies, the ratios would be based on those established for the smallest groups. In determining the ratio for a particular policy, consideration would be given to the average ratio for similar carriers offering certified policies. After its initial determination of the ratio for a policy, the Department would periodically review and evaluate experience under the policy to determine if the policy continues to meet these requirements.

Group Practice Plans

The requirements for certification would not specifically apply to comprehensive-prepaid group practice plans, but special requirements would be developed that would be equivalent on an actuarial and benefit basis to the general requirements.

Administration of the Program

A carrier which wishes to offer certified insurance must agree to offer to all individuals and families in each geographic area of the State in which it does health insurance business (1) a policy which meets the requirements for certification described above and (2) a policy which when combined with an approved private catastrophic plan meets the requirements for certification. The carrier could offer these policies through insurance pools or other arrangements described below.

Carriers would submit policies to the DHEW for approval as certified policies. If HEW determines the policy meets the requirements, it would certify the policy for use in States which have established a qualified basic health insurance facilitation program. (These programs are described below.) Carriers with certified policies would be required, under HEW regulations, to periodically report information concerning the policy to the Department and procedures would be established for continuing review by the Department of compliance with the certification requirements.

States which have established a qualified facilitation program could, at their option, agree with DHEW to make determinations on behalf of the Department of the qualifications of health insurance policies for certification. These duties would be performed by State insurance departments which would be reimbursed by the DHEW for their reasonable expenses in carrying out these duties.

Emblem of Certification

The Department would designate an emblem of certification showing that a policy is certified. Carriers could use this emblem and other indications of certification in advertising the policy to the public.

A carrier which (1) offers certified insurance in all areas in which it does business and (2) uses effective procedures, through means consistent with practices in the insurance industry, to control utilization and costs of services under its policies would be given the status of an approved carrier. Beginning 3 years after the start of the program, only approved carriers could qualify as intermediaries or carriers under the Medicare program or the proposed medical assistance program.

Antitrust Laws

The bill would suspend Federal, State, and local antitrust laws to permit carriers to enter into insurance pools, reinsurance arrangements, and similar contracts and combinations (which may now be illegal under some of these antitrust laws) for the specific purpose of offering certified health insurance. These arrangements must be approved in advance by the DHEW.

Basic Health Insurance Facilitation Program

States would establish basic health insurance facilitation programs by enacting laws and regulations establishing insurance pools, reinsurance or similar arrangements for use by carriers offering certified health insurance. The premium charged for certified insurance under these pools or arrangements must be between 125 and 150 percent of the average rate in the State for a group of 10 persons. All carriers doing health insurance business in the State must be required to participate in these arrangements and share any losses in proportion to their business in the State. The DHEW would examine the laws and regulations of the States and determine whether they have qualified facilitation programs.

Insurance Offered by DHEW

Three years after enactment of the bill, the DHEW would report to the Congress on the extent to which certified insurance is available in each State and the extent of coverage under these certified policies in each State.

Also 3 years after enactment, the DHEW would establish a special program which would offer certified health insurance to residents of those States which have not established qualified facilitation programs and in which

no approved certified insurance is available. This special program would be administered by the Department using the same payment methods and mechanisms used under the Medicare program. The premium charge for this insurance would be an amount designed to cover the cost of the insurance, including its benefit and administrative costs and necessary reserves. As needed, Federal revenues could be appropriated to establish a contingency reserve for the program; these funds would be repayable to the Treasury without interest. An insurance revolving fund would be established to handle the funds of the program.

OTHER PROVISIONS OF THE BILL

The bill includes additional provisions all of which affect the Medicare program and most of which also affect the proposed catastrophic, medical assistance, or basic health insurance certification programs.

Benefit Provisions

Types of immunizations considered appropriate under DHEW regulations would be covered under the Medicare and catastrophic insurance programs. Payment for these immunizations under Medicare and the government-administered catastrophic program would be made on the basis of a scheduled allowance (fee schedule).

Payment under Medicare for treatment of mental disorders on an outpatient basis, now limited to 50 percent of charges up to a maximum of $250 in a year, would be liberalized to 80 percent of charges up to a maximum of $400. This change would make the Medicare provision comparable to that under the basic health insurance certification program.

Reimbursement Provisions

Both the Medicare and Medicaid laws require that skilled nursing homes be reimbursed on a basis related to costs, but the amount of reimbursement is generally not the same because the method of determining costs used by the Medicare program is generally not the same as the methods used by each of the State Medicaid programs. The bill would permit the Medicare program to pay the same rates to SNF's as are paid by the various State Medicaid programs or, to take into account any additional services and requirements under Medicare, up to a maximum of 10 percent additional.

The bill expresses the policy of Congress that philanthropic support for health care should be encouraged especially to support innovation efforts

to improve health care access and delivery. The provisions for reimbursement of hospitals and other institutions under Medicare, the government-administered catastrophic insurance programs, and the medical assistance program would treat philanthropic contributions as follows:

(1) Grants, gifts, and endowment income which are unrestricted by the donor would not be considered operating income to the institution and thus would not be deducted from operating costs for determining reimbursable costs.

(2) Grants, gifts, and endowment income designated by the donor for paying operating costs would be considered operating income and would be deducted from operating costs.

(3) Investment income from grants and gifts would be considered an offset against the interest expense of the institution and would be deducted from interest expense, but only if the grant or gift is unrestricted and is commingled with other funds and then only up to the maximum of the total interest expense of the institution.

Eligibility Under Medicare

Under present law, persons age 65 and over who are not insured for hospital insurance coverage under Medicare may voluntarily enroll by paying a premium which is based approximately on the actuarial value of this coverage. Under the bill, the enrollee would pay one-half this premium and the Federal Government would contribute one-half (financed from Federal general revenues).

Under present law, persons must be insured for Medicare (or be a dependent of an insured person) to be eligible for benefits under the renal (kidney) disease provisions of the Medicare program. This insured status requirement would be removed for persons not meeting it on the date the bill is enacted. The cost of benefits for this group of uninsured persons would be financed from Federal general revenues.

ROE BILL

The "National Catastrophic Illness Protection Act of 1975" was introduced by Representative Robert A. Roe of New Jersey as H.R. 1373.

General Concept and Approach

The proposal would establish a program of private health insurance protection against the cost of catastrophic illness. Persons could voluntarily buy private insurance policies that would pay for medical expenses which exceed a specified amount, with the amount depending on family income and size. The program would be administered by private insurance carriers under State supervision. The premium would be paid by the policyholder, but the Federal Government could subsidize the premium, using funds from general revenues. The Federal Government would also administer a reinsurance plan for insurance carriers under the plan.

Coverage of the Population

All persons could obtain coverage on a voluntary basis.

Benefit Structure

For the purpose of this program, any services defined as medical care under the present Federal income tax law relating to medical expense deductions could be included in a State plan.

The policies would pay the medical expenses of individuals and families whose expenses exceed a specified amount (referred to as the annual deductible). This deductible would vary according to family income and number of dependents. For low-income people no annual deductible would be applicable (and thus the plan would pay for all covered medical expenses) but the deductible would rise rapidly as family income increased.

The amount of the deductible would be based on the family's "adjusted income," which is the "adjusted gross income" shown on the Federal income tax return reduced by the total amount of personal exemptions. In calculating the deductible, the first $1,000 of "adjusted income" would be disregarded and the deductible would be equal to (1) 50 percent of adjusted income between $1,000 and $2,000, plus (2) 100 percent of adjusted income over $2,000. An illustrative schedule based on this formula for a family of four follows:

Adjusted gross income	Adjusted income 1/	Annual deductible
$1,000.....	None	None
$4,000.....	$1,000	None
$5,000.....	2,000	$500
$7,500.....	4,500	3,000
$10,000.....	7,000	5,000
$20,000.....	17,000	15,000
$30,000.....	27,000	25,500

1/ Based on personal exemption of $750 per person.

In figuring the family's medical expenses, medical costs paid in a year for continuous, uninterrupted care which began in an earlier year would be considered to have been paid in the earlier year.

All medical expenses incurred would count toward meeting the deductible including expenses paid by other private insurance or covered by Medicare, Medicaid, or other public programs.

Administration

Each State would design its own health insurance plan under regulations of the Department of Health, Education, and Welfare. The State insurance department would make arrangements with, and supervise, private health insurance carriers who would sell the insurance, collect premiums, and administer claims.

A carrier organization would be established in each State that would attempt to distribute the risks equitably among the insurers. Special insurence pools or assigned risk pools would be established to provide coverage for persons unable to obtain coverage at the regular premium rate.

The Department of Health, Education, and Welfare could administer a plan in any State that has not established one.

Relationship to Other Government Programs

Medicaid and other assistance programs would be affected because they would not make payment for the services covered by the insurance. Most other Government programs would not be affected.

Financing

Periodically, the Department of Health, Education, and Welfare would determine the actuarial value, according to family size and composition, of the catastrophic insurance policy in each State. The Department would then establish a premium rate which could be lower than the actuarial value, if the Department believed that a lower rate was desirable in order to obtain more widespread coverage. The Federal Government would pay the insurance carrier the difference between the actuarial value and the established premium. These payments, referred to as premium equalization payments, would be paid from Federal general revenues through a national catastrophic illness fund.

The Department would also arrange for reinsurance for carriers and for State pools to protect them against unexpected losses in connection with the catastrophic insurance. The premiums for this reinsurance would be paid by insurers in an amount determined by the Department. This reinsurance plan would also be administered through the national catastrophic illness fund and the Department could contract with private firms to handle the reinsurance claims.

Other

There are no provisions in the bill concerning standards for providers of service, reimbursement of providers, or health care delivery and resources.

APPENDIX

MEDICARE PROGRAM
STANDARDS FOR PROVIDERS OF SERVICES

In order to participate in the Medicare program, providers of services have to meet certain statutory requirements and other health and safety requirements established by the Department of Health, Education, and Welfare.

Hospitals

General hospitals must be licensed under State law, maintain clinical records for all patients, have by-laws for their medical staff, have every patient under the care of a physician, provide 24-hour nursing service, and have a utilization review plan in effect. They must also meet health and safety requirements regarding their physical environment and the operation of their facilities and services.1/

Hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet all the conditions of participation (except utilization review) although the Department has authority to establish standards higher or more precise than those of these organizations.

Tuberculosis and psychiatric hospitals must meet the same requirements as general hospitals and must be accredited by the Joint Commission as well as meet special requirements for medical records and staffing.

Skilled Nursing Facilities

Skilled nursing facilities must be licensed under State law, must maintain clinical records for all patients, have established policies regarding patient care, have every patient under physician supervision, provide 24-hour nursing service, have established procedures for dispensing drugs, and have a utilization plan in effect. They must also have a transfer agreement with a hospital and meet health and safety requirements regarding their physical environment and the services they provide. They are specifically required to meet the provisions of the Life Safety Code of the National Fire Protection Association applicable

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1/ Nonparticipating hospitals may provide emergency services under Medicare and these hospitals must be licensed under State law and provide 24-hour nursing service.

to nursing homes which the Department holds to be appropriate. They must also cooperate in an effective program of independent medical evaluation and audit of their patients.

Home Health Agencies

Home health agencies must provide skilled nursing services and other therapeutic services, be licensed under State law, maintain clinical records for all patients, have established policies for their services, and meet additional health and safety requirements.

Providers of Outpatient Physical Therapy Services

These providers include participating hospitals, skilled nursing facilities, and home health agencies. Clinics, rehabilitation agencies, and public health agencies can also be providers of outpatient physical therapy services if they are licensed under State law, maintain clinical records for all patients, provide an adequate program of physical therapy services for outpatients, have established policies for their services, and meet additional health and safety requirements.

Independent Laboratories

Independent laboratories must be licensed under State law and meet health and safety requirements regarding the qualifications of their personnel, recordkeeping, and the operation of their equipment and facilities.

Physicians and Other Professionals

Physicians must be legally authorized to practice medicine or surgery by the State in which they provide their services. Chiropractors, dental surgeons, and podiatrists have to meet similar requirements with respect to their services.

Other Suppliers of Services

Suppliers of portable X-ray services must be licensed under State law, and must meet health and safety requirements relating to physician supervision, qualifications of personnel, and safety standards for their equipment. Suppliers of ambulance service have to meet safety requirements for their ambulances and have trained personnel.

All Institutional Providers

All institutional providers are required to have a written plan reflecting an operating budget and a capital expenditures budget for the next 3 accounting years.

Discrimination Prohibited

Participating hospitals, skilled nursing facilities, and home health agencies must comply with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin.

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Medical Care Costs and Prices: Background Book: 97 pp. $1.70

Released February 1976. Offers comprehensive data on the costs and prices of hospital care, physicians' and dentists' services, and other components of medical outlays, and on significant trends and factors in such expenses.

Selected State Data Medicare Fiscal Years 1968-72: 54 pp. 85 cents

Released March 1976. Summarizes basic Medicare information for each State, the District of Columbia, and Puerto Rico; data on enrollment, amounts reimbursed, the providers of services, as well as some utilization data for hospitals and extended care facilities.

Size and Shape of the Medical Care Dollar 1975: 36 pp. 80 cents

Released November 1975. A two-color chartbook which presents in graphic form the background facts relating to the medical care dollar--who pays; what and how much is bought; for whom it is spent; and how and why it has grown.

Compendium of National Health Expenditures Data: 122 pp. $2.30

Released March 1976. Tables comprise all available data on health expenditures from 1929 to 1974. The data cover not only direct consumer outlays for medical care and the proportion paid by private health insurance but also include health outlays by public programs and by other sources of payment such as private health insurance, direct payments, and philanthropy.

Personal Health Care Expenditures by State, Volume I: 151 pp. $2.40

Designed to assist State government officials, State and local planning agencies, and health researchers involved in the coordinated planning, organization, and delivery of medical care services at the State and local level. State data are presented for each public program by source of funds and type of expenditure for fiscal years 1966 and 1969 to provide some measure of the impact of Medicare and Medicaid.

Personal Health Care Expenditures by State, Volume II: 82 pp. $1.95

Presents State estimates of total spending by source of funds and type of expenditures. Includes both public and private programs.

Social Security Programs in the United States: 133 pp. $1.20

Brings together information through July 1973 on the historical development and present status of all the major income-maintenance programs in the United States and on the health insurance and medical assistance programs under the Social Security Act.

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